			1 - For State Registrar	State of	•	epartment of Certificate of		F	Reg. No.2 U ()	4 21001
П	Physici	an	Decedent's Name (First, Midd.  CAROLYN	e, Last) M.		RAYMOND		2. Date of Dea Month JUNE		3. Time of Death 4:00 P. M
*	/Medic Examir		4a. Facility Name (If not institution GENESIS ELDER	n, give street and numb			or Location of Dea		4c. County of	
	Funeral Director		5. Social Security Number 216-09-1504 Usuel Residence of Decedent	6. Sex 7. 1 ☐ M 2 <b>XX</b> F	Age (In yrs. last birth	Months Davs			7, Year) 119	9. Birthplace (State or Foreign Country) MARYLAND
	yland how		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	72 hours after death with the Maryland natural', or Items 23e or 28e-f show lited Exantrative be notified at	Director	MD N/	A	BAL	TIMORE CIT	Y			1 XYes 2 No
	with the	Dire	10e. Street and Number 1214 GITTINGS	ATTENITIE		10f. Zip Code 2123	0		10g. Citizen of Wh USA	nat Country?
	death ms 23	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S.	13. Was Decedent of If Yes, specify Cu		Specify Yes or No-		- American Indian,
9	or Ite	/ Fur	1 Never Married 2 X Mar	If Yes, Give	ĬχNο	If Yes, specify Cu		no Hican, etc.)	Specify:	White, etc.
5-0036	hours tural',	ed by	3 Widowed 4 Divorced	Year or Date	es:	ecedent's Usual Occi	ination		16b. Kind of Bus	WHITE iness/Industry
215	nin 72 n "nai Wedic	Completed	(Specify only higher	st grade completed)  College (1-4	(	Give kind of work done ife. DO NOT use retir	e during most of wa	orking	TOD. KING OF BUS	moss moderny
7	filed within Hygiene. other then "	Com	9TH GRADE			HOMEMAKER			OWN HOM	
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Exacting results to notified at	To Be	17. Father's Name (First, Middle, JOSEPH WAZKO					ime <i>(First, Middl</i> e, LLA PAWTC		)
aryl	2 shoul and Me Is mark	Ĕ	19a. Informant's Name/Relations	ship (Type, Print)		Mailing Address (Stree	et and Number or P	Rural Route Numbe		
	1 and 2 Health a tem 27 ls		BARBARA RAYMON	D DAUGI		214 GITTIN	GS AVENU	The same of the	ORE, MD	21239
altimore,	0 0 == =		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation		ate cemetery	Disposition (Name of crematory or other pi		Date		City or Town, State
Ħ	permit. Pag Department Importent: I any injury o		* 4 □ Donation 5 □ Other (S 21. Signature of Funeral Service	- 1	GARDEN	S OF FAITH 22. Name and Add	F 80 - 10-	- 0.0	PARKVILL	
Ba	Departing any ir.		trather	N. Hu	h	8521 LOC		E JOHNSON		L HOME, P.A. 21286
}	Physician /Medical Examiner		23a, Fart1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause on day  a	sed the death. Do not hine.  State of the death of the death. Do not hine.	Cerebr		ec or respiratory and	Λ	Approximate Interval Between Onset and Death Leas
8760,	cate be executed by sician and the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>S</b>	r as a consequence of					
P.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		h 2 Fetal death	3 □Ectopic pregnan 5 □ Other (specify)	су		23d. Date - Mont	of delivery h Day Year
	w requires that been signed b should be deta	ρ	Part II. Other significant conditi	ons contributing to dea	th but not resulting in	the underlying cause of	given in Part I.	23e. Did to	_	oute to the cause of death?  B Probably 4 Dunknown
I Records,		Completed				-		24a. Was autop perfor	rmed? pr	ere autopsy findings available for to completion of cause of eath?
Vital	Physician: this certific ral director,	Be	25. Was case referred to medica examiner?	Hoenitals				eath (Check only o		1521
of	Phys r this ral dir	- To	1 Yes 2 No 27. Magner of Death	28a. Date of	natient 2 ☐ ER/Outp	atient 3 DOA		Home 5 Resid	lence 6 Other	
ion	Attending Firdeath. actor: After by the funera	ation	1 Natural 5 ☐ Pendi		Day Year) Inj	ury W	ork? ∐Yes 2∐No			
Division of	l or Atte after dea Diracto in by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 288. Place o	f Injury - At home, farr g, etc. (Specify)	n, street, factory, office	9	28f. Location (S City or Tow	Street and Numbe m, State)	r or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifyi (Check only one) 1 Medical	ng Physicien: To the b Examiner: On the bas and manne	is of examination and	death occurred at the for investigation, in my	time, date and place opinion, death occ	ce, and due to the courred at the time, o	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	To the within To the comp	M	29b. Signature and title of certific	hon	que	29c. Lice	3066	/	29d. Date signed	(Month, Day, Year) 29th 2004
	3		30. Name and address of person	who completed cause	of death (Item 23a) (T	ype Print) Ba	eltina	30 - 1	d 21	239
	Sta Registr	-	31. Date filed (Month, Day, Year, JUL 0 2 20		gistrar's Signature	Sparks	,			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Ocelia Robinson 24, 2004 4c. County of Death 10:00P June\_ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Howard Columbia Lorien Nursing Home Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Hours 1 □ M 2 K F Director Feb. 05, 1905 VA 402-03-3150 Usual Residence of Decedent 99 with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State r than "natural", or Itams 23a or 28a-1 show the Mudical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** Columbia Howard MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21044 Honest Scene Lane 5510 filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 XNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 african 1 ☐ Yes 2 🛛 No Specify: Completed by **¾**Widowed 4 □ Divorced Year or Dates: american 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Insurance 10 Agent 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 Ia marked offul any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Alice Pettis Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5021 Eliots Oak Road, Ellicott City, MD. 21044 Clemma C. Younger/cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Vine Street Cem. 07/02/04 Cincinnati, Ohio ' 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 5555 Twin Knolls Rd.Columbia, Md.21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) reunoma Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical F FFMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐ Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ should be omentia 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed advencel 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 2 X No 1 ☐ Yes 1 Yes this certificate or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident after death Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To tha Hospital o within 24 hours aff To tha Funaral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 150370 na Bell in Clarksille mD 21029 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) bdo MD 5005 Suzan M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 2 2004 Registrar

**ORIGINAL** 

John C. Ross Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-4231 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar AKG Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** John C. Ross June 28, 12:50 P 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 725 Eden Farm Circle Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F 195-56-0561 Director May 3,1960 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1x Yes 2 □ No PA Bedford Imler 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 162 Pavia Road 16655 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 🎇 No If Yes, Give 1 ☐ Yes 2 ₺ No Specify: If Yes, Give Year or Dates: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ĺ2 Carpenter Contracting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James W. Ross A. Joyce Miller 19a. Informant's Name/Relationship (Type, Print) (Funeral Director) 188 Bedford Street Claysburg, PA 16625 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Funeral Home 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ortant: If i 1 Burial 2 □ Cremation 3 N Removal from State permit. Page Department of Important: If any injury or once. '4 ☐ Donation 5 ☐ Other (Specify)

21. Signature rai SerVic Icensee Pavia Cemetery 7-3-2004 Imler, Pennsylvania Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, MD 212281 MO1290 23a. Part1. Enter r e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or havin failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute (or spaces Throm, bo SIS disease or condition resulting in death) Atheroscleration cardinas cular diseaso Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or). Examiner as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? 1 🗶 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Cther: 1 XYes 2 □ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ★ Other (Specify) At scene 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours a Funeret I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical The Certifying Physician: To the dest of my knowledge, death occurred at the time, date and place, and does not no causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only

Registrar

one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of darn (Item 23a) (Type, Print) Tasha Z Greenberg 31. Date filed Winth, 0a2Ye2004 SP Registrat's Signature

Jaska & Greenhere

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

June 29, 2004

29c. License number

O.C.M.E.

DHMH 17 Rev 1/2001

within 2. the

alp

		For State Registrar	State of Maryla	-	urtment of H tificate of I			iene g. No O N	01001
Physicia		1. Decedent's Name (First, Middle, Last)	istopher Ra	msev			2. Date of Death	1 600	3. Time of Central
/Medic Examin		4a. Facility Nama (If not institution, give st. UNIVERSITY OF MAF			4b. City Town of	ORE CITY		4c. County of I	
Funeral Director		5. Social Security Number 6. Sex 1X	4 200	rs. last birthday) 10 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, SEP 23,	Year) 9.	Birthplace (State or Foreig Country) Nebraska
aryland ehow	2	Usual Residence of Decedent  10a. State  10b. County	10c.	City, Town or Lo					10d. Inside City Limit
with the M	Director	Maryland N/A  10e. Street and Number  107 South Arlingt	on		Baltimo	ore 21223	10	og. Citizen of Wha	
within 72 hours atter death with the Maryland ene. then "neturel; or Items 23s or 28e-f ehow the Wadisal Exart attribute at	by Funerai		2. Was Decedent Ever in Armed Forces? 1	1	Was Decedent of H	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
within 72 hou ene. then "neture	Completed	(Specify only highest grade	ition	16a. Deced (Give life. L Labor		ation during most of work f)	ing	66. Kind of Busin	,
uld be filed fental Hygi rked other IIc event, I	To Be Co	17. Father's Name (First, Middle, Last) Robert W. Ramsey		Labor			e (First, Middle, N n Profit	faiden Sumame)	CLIOII
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23s or 28e-1 ehow any injury or other treumetic event, the Mudical Examt nativitation or other treumetic events.	(3)	19a. Informant's Name/Relationship (Type Carolyn Ramsey/mot 20a. Method of Disposition 1 □ Burial 2 Cremation 3 □ Re	her 20t	111 D. Place of Dispo	Two Pond sition (Name of natory or other place	Loop La	dson, SC		
permit. Pages 1 a Department of Hes Importent: If Item any injury or othe		1 □ Burial 22 □ Cremation 3 □ He  '4 □ Donation 5 □ Other (Specify)  21. Signature of Forteral Service Licenses	Moval from State M	Metro Cr	ematory,	Inc. 7/2 ss of Facility Society			ore, MD
Physician /Medical Examiner		Thomas Greg  23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  a.	ations that caused the de	eath. Do not ent	299 Frede er the mode of dyin	g, such as cardiac	or respiratory arre	nore, MD	Approximate Interval Between
ate be nysicia he bui	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons						
ath certit ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of predictions of the second sec	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
quires that the de n signed by the a uld be detached t	þ	Part II. Other significant conditions conti	ibuting to death but not	resulting in the u	nderlying cause giv	en in Part I.		~	te to the cause of death?  Probably 4 Unknow
	Completed						24a. Was ar autopsy perform 12 Yes 2	/ prior	e autopsy findings availab to completion of cause o th? Yes 2 \(\sumbolea\) No
ding Phyei T. Atter this c funeral dire	tion: To Be	25. Was case referred to medical examiner?  1X Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	spital: XXInpatient 2 28a. Date of Injury onth, ay Year	28b. Time of Injury	28c. Injun Worl	er: 4 🗆 Nursing Ho	th (Check only one ome 5 □ Reside 28d. Describe ho	nce 6 Other (	specity) au Hed
To the Hospitel or Attendi within 24 hours atter death. To the Funeret Director: A completely tilled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str	/1		28f. Location (Str City or Town		or Rural Route Number,
To the Hospitel or within 24 hours after To the Funeret Direction completely tilled in	Medical	(Check only and one)	cien: To the best of my ler: On the basis of exame and manner stated.	knowledge, death ination and/or in	vestigation, in my o	pinion, death occur	red at the time, da	ite and place, and	due to the cause(s)
To To Com	2		elan N			СМЕ		JULY 1,	2004
C		30. Name and address of person who com Carol H. Allan,	pleted cause of death (I	tem 23a) (Type,	111 Per	nn Street	, Baltim	ore, Mar	yland 21201
Sta Registra		31. Date filed (Month, Day, Year)	32/Registrar's Sig	gnature	relie				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 8. Time of theath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2:30 AM **Physician** RICH AY DSOY 2004 ohn Unc /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street and number) Examiner Future Care Homewood Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1⊠M 2□F Months Hours 065-10-7296 98 Yrs. Feb 21, 1906 Pennsylvania Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County MD Baltimore ty Yes 2 □ No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3501 St. Paul Street #5 21218 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2\(\frac{\text{\Delta}}{1}\) No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 ☐ Widowed 4 🖾 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 violinist music 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be ဂ John Thomas Richardson Lillian Osmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frieda Lenthe/niece 242 Gleaves Road S rin field, PA 19064 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Signature of Euneral Service Licensee ROD Ld S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical 72 hours Examiner Physician/Medical Examiner trition MAINU or Attending Physician: The law requires that the death certificeta be executed anding physiclan and usa as the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. 0 6 PX 122 21011 Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No pertension ģ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? certificate has page 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 | Yes 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of Injury 28c. Injury et Work? 5 Pending investigation 1<sup>™</sup> Naturel efter death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Atterviewithin 24 hours efter des To the Funeral Director completely filled in by the 3 Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier mma 24,2004 Imally 035102 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

Registrar

HILANI

31. Date filed (Month, Day, Year)

JUL 0 2 2004

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32. Registrer's Signeture

m.D

Don

Tunbridge RUAd BAILMORT

MANYINNO

Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physicien: thin 24 hours a within To the

State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

f

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

NULL

29d. Date signed (Month, Day, Year)

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			State	OI Maryi		ertificate of	neaith and i Death		Reg. No.2	nı.	21007
		1. Decedent's Name (First, Mi	ddle, Last)					2. Date of De		Year	3. Time of Death
4	Physician	HANNAH EL	TZA READD	7				JUNE 2			1:20a
	/Medical Examiner	4a Facility Name (If not institu					4b. City, Town, or L	ocation of Death	4c. County	of Death	
	Examiner	FUTURECAR	E HOMEWOO!	D NURSI	NG CENT	TER	BALTIMO	ORE	N/		
	Funeral	5. Social Security Number	6. Sex		rrs. last birthda	y) If Under 1 Yea Months Days		8. Date of Bir (Month, De	th y, Yeer)	9. Birthpla Countr	ice (State or Foreign y)
	Director	215-78-8157	1 □ M 2 □XF		89 Yrs.			9-17-1	914	VIRGI	NIA
	p ≥	Usual Residence of Decedent 10a. State 10b. Cou	ntv	10c	City, Town or	Location				100	d. Inside City Limits
	show show		N/A		BALTIMO						1 X Yes 2 □ No
	vith the Mar t or 28a-f s be notified Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Countr	v?
	uth with the Marylen 23a or 28a-f show ust be notified at rai Director		NI ANTE			212			USA		•
	erai	4410 ELDERO		ecedent Ever i	n U.S. 13			pecify Yes or No		e - America	n Indian,
020	72 hours after deeth with the Maryland natural, or items 23a or 28a-f show disal Evanirer must be norithed at eted by Funeral Director	1 □ Never Married 2 □ M 3 ☑ Widowed 4 □ Divor	Armed 1 ☐ Ye	Forces? s 2[X]No Give r Dates:		If Yes, specify Cu 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	o Rican, etc.)		ck, White, et	
0	ed within 72 hours s ygjene. ner than "natural", o rt. tra Medical Exar Completed by	15. Dece	dent's Education	and)	16a. Dec	cedent's Usual Occu	upation e during most of work	kina	16b. Kind of Bu	ısiness/Indu	ıstry
216	thin 7	Elementary/Secondary (0-1		a (1-4or 5+)	life	. DO NOT use retir	e during most of work ed)	9			
2	filed within Hygiene. ther than * ent, the Me	-12-		-0-		HOUSEWI			DOME		
p	ニエショ へ	17. Father's Name (First, Mide					18. Mother's Nam			10)	
yla	should be and Mental marked o umatic eve	FRANK CARTE						GIE SEBI	-		
, Maryland 21215-0020	d 2 sho th end 7 is m traum	19a. informant's Name/Relati MARY PERRY (					ot and Number or Ru ON AVE. BA	ALTIMORE	E, MARYL	AND 2	1215
Baltimore,	Peges 1 an nant of Heal int: if Item 2 iry or other	20a. Method of Disposition  1  ☐ Burial 2  ☐ Cremati  4  ☐ Donation 5  ☐ Other		om State	cemetery, c	position (Name of rematory or other pi NATIONA	L CEMETERY		20c. Location -		
Balti	pemit. Pege Depermant of important: If any Injury or once.	21. Signature of Funeral Serv	ice (consum JON)	ATHAN D			• MONROE				AND 21217
	-	23a. Part1. Heter the disease shock, I'r heart failure.	or complications th	at caused the c	leath. Do not e	enter the mode of dy	ying, such as cardiac	or respiratory a	rrest,	1	Approximate Interval Between
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)		horo:		tic He	eurt De				Onset and Death  I Mon: Hh
,x 68760,	asth certificate be executed attending physician and for use as the burial-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	6		o (or as e cons						
Вох	eath cert attendin I for usa clan/N	Danie Ottoriei and	Plate and a section bine to	- death but not	requising in the	undarlying goven	nivon in Part I	23h Did	tohacco use co	ntribute to	the cause of death?
P.O.	nat the death cert d by the attendin letached for use Physician/N	Part II. Other algnificant con	artiona contributing to	o death but not	resulting in the	underlying cause (	given in rait i.				ably 4 Unknown
Division of Vital Records,	The law requiras that the death centrate has been signed by the attending page 2 should be detached for use Completed by Physician/N							24a. Was	an autopsy ormed?	avai	re autopsy findings ilable prior to apletion of cause eath?
æ	he law ta has aga 2							1 🗆	Yes 2 No	1 🗆	Yes 2010
ta		25. Was case referred to me	dical				26. Place of Dea	ath (Check only	оле)	1	
$\geq$	Physician: The I this certificata ha ral director, paga 1: To Be Com	examiner? 1 ☐ Yes 2 🗹 No	Hospitel: 1	☐ Inpatient	2 🗆 ER/Outpal	ient 3 DOA	Other: 4 Nursing H	ome 5 Res	dence 6 □Oth	er (Specify,	)
ion o	£ ± =	27. Manner of Death 11 ☑ Natural 5 ☐ Pe 2 ☐ Accident inv		ate of Injury fonth, Day Yea	r) 28b. Time Injur	y W	juryat /ork? □Yes 2□No	28d. Describe	how injury occur	red	
Divis	tal or Attanding Prs after death. al Director: After tied in by the funers Certification:	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide	uld not be termined 28e. Pi	ace of Injury - a uilding, etc. (Sp	At home, farm, pecify)	street, factory, offic	ee ·		Street and Numb wn, Stete)	oer or Rural	Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral Medical Certification:	29a. Certifier 1 Cert (Check only one) 2 Med	fying Physician: To cal Examiner: On th and n	the best of my e basis of exar nanner stated.	knowledge, de nination end/or	investigation, in my	y opinion, death occu	rred at the time,	date and place,	and due to	the cause(s)
	within To the comp	29b. Signature and title of ce	tifier			29c. Lice	nse number		29d. Date signe	d (Month, E	Dey, Year)
	/	Melinah	J-Kun			110	45931		June	28,	2004
	ģ	30. Name end address of per	son who completed of		(Item 23a) (Typ	pe, Print) Parich	teights	Aveno	re Be	aithn	oey, Year) 2004 naro, MD
**************************************	State Registrar	31. Date filed (Month, Day, Y	2004 ×	Registrar's S		Sporks					

JUNE 25, 2004

			For State Registrar	State of Ma		ertificate of		Mental Hyg	iene •g. No. () () (	21008
	Physici	an	1. Decedent's Name (First, Middle, La. Ruth	st)	Smith			2. Date of Deat Month June 3	0, Day 2004	3. Time of Death 8:04 PM
>	/Medic Examin		4a. Facility Name (If not institution, given 12009 01d Colum				or Location of De	ath	4c. County of Death Montgome	)
	Funeral Director		377 00 0702	ex 7. Age	(In yrs. last birthday 54 Yrs.	/) If Under 1 Year Months Days			9. Birth 2004 Was	place (State or Foreign Mington, DC
	f ehow	ō	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgo	mery	10c. City, Town or I Silver	ocation Spring				10d. Inside City Limits 1 ☐ Yes 2 🖔 No
	ith the A or 28a-1	Funeral Director	10e. Street and Number			10f. Zip Code		1	Og. Citizen of What Co	•
	eath w	erail	1501 Hampshire W	est Ct.	verin U.S. 13		20903	(Specify Yes or No-	United S	
920	be filed within 72 hours after death with the Maryland tal Hygiene do ther than "natural", or itema 23a or 28a-f ehow event, its Marjoal Examina must be notified at	þ	1 Mever Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 N  If Yes, Give  Year or Dates:		If Yes, specify Cul		(Specify Yes or No- erto Rican, etc.)	Black, White	
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra		(Giv	edent's Usual Occure kind of work done DO NOT use retire	e during most of v	vorking	16b. Kind of Business/l	ndustry
21215-0036	d within giene. Ir than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5- 12	+)	etary Sup			Nursing	Home
Maryland ;		To Be C	17. Father's Name (First, Middle, Last, Kenneth	Smit	h		18. Mother's N	lame <i>(First, Middle, I</i> icia	_	erry
Mary	12 hai		19a. Informant's Name/Relationship ( Karen Smith	<sub>Туре, Print)</sub> (Daught					r, City or Town, State, Z er Spring, M	
Baltimore,	es 1 ar of Hea if item ir othe		20a. Method of Disposition 1 ☐ Burial 2 ※ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specif			position (Name of ematory or other place are Crema			20c. Location · City or T	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer	7	1100382	<sup>22</sup> Rampand Full 933 Gist	reralian L Ave.,	d Crematic Silver Spi	on Services ring, Md. 2	0910
}	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	aDue to (or as a	the death. Do not e	CQ NC	_	liac or respiratory arm	est,	Approximate Interval Between Onset and Death  Munths
Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical Examiner	in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. Due to (or as a d.  d.  23c. If yes, outcome (1 Live birth 4 Pregnant at 1	2 Fetal death 3	□Ectopic pregnan	icy		23d. Date of delifing Month	very Day Year
P.O.	that the de ed by the detached		1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown			uven in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
rds,	v requires been sign should be	ed by						1 □ Ye	es 2 No 3 ☐ Pro	bably 4 Unknown
il Records,	The ate h page	Completed	1)					24a. Was a autops perform	sy prior to d	topsy findings available ompletion of cause of 2 \square No
Vital	Physician: Th this certificate ral director, pa	o Be	25. Was case referred to medical examiner?	Hospital:		D	thor	Death (Check only on		Daughters
of	Jing After fune	1-	1 Yes No  27. Manner of Death Natural 5 Pending 2 Accident investigatio	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Inj	4   Nursing	_	ence 6 <b>X</b> Other ( <i>Spe</i> c ow injury occurred	ify) Home
Division	2 2 2 6	Certification:	3 Suicide 6 Could not be determined		ry - At home, farm, : . <i>(Specify)</i>	street, factory, office	Э	28f. Location (St City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edicai (			examination and/or				ause(s) and manner as late and place, and due	
	To the To the Comp	ž	29b. Signature and title of certifier	.</td <td></td> <td>00</td> <td>nse number</td> <td>-</td> <td>9d. Date signed (Month</td> <td>, Day, Year)</td>		00	nse number	-	9d. Date signed (Month	, Day, Year)
	2		Fello A	Merer m	Ø	U2	1910	J	July 1, 20	04
	Sta		30 Name and address of person who ETEK B, SH 31. Date filed (Month, Day, Year)	ERER m	r's Signatuge	party fe	RRARA	OR	WHEATON	1 mp 20906
	Registi		JUL 02 2004	Sengua	19	Sparker				

DC	)S		For State	State of Maryla	•	artment of H			2006	21000
			Registrar  1. Decedent's Name (First, Middle,	Last)	Cel	uncate of t	Dealii	2. Date of Death	. N6. UU4	3. Time of Death
п	Physicia		Joehan	Saiter				Month June 2	Day Year 9. 2004	1930 p <sup>M</sup>
¥	/Medic Examin	100	4a. Facility Name (If not institution,	give street and number)			Location of Death		4c. County of Death	_
		· Ur	1000 Hilltop			Catons			Baltimo	
	Funeral Director		5. Social Security Number 583-21-1039	3. Sex 7. Age (In yr	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y June 6, 1	ear) 1973 Pue	place (State or Foreign intry) rto Rico
	pu 🛦 .		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Maryla a-f sho	ctor	Maryland Balti			Ov	vings Mil	<b>1</b> s		1 □ Yes 2 No
	with the se or 28	Director	10e. Street and Number 4 Bitterroot (	St. #2B		10f. Zip Code	21117		p. Citizen of What Cou Inited Stat	•
	death ms 2;	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H if Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-	14. Race - Ameri Black, White	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Itlant 27 is marked other then "natural", or items 23s or 28s-f show item 27 is marked other then "natural", or items after event, I as Medical Example or I as the mailing a	by Fu	1 Never Married Marrie 3 Widowed 4 Divorced	nd 1 □ Yes 2 No If Yes, Give Year or Dates:		1 X Yes 2 No		to Rican	Consitu	nite
9	2 hou	ted	15. Decedent's	s Education	16a. Dece	dent's Usual Occup	ation	16	6b. Kind of Business/Ir	ndustry
21215-0036	within 7 ane. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	ecurity l	3)		Security (	Company
	filed Hygid other ant, I	Be Co	17. Father's Name (First, Middle, L			courtey i		e (First, Middle, Ma		Sompariy
Maryland	12 should be filed within 7 n and Mental Hygiene. 7 Is marked other then "reumatic event, It - Med	To B	Jose	Saiter	,		Luz		Rivera	
	and 2 sho salth and n 27 Is m		19a. Informant's Name/Relationsh Israel Gonzalez			-		ral Route Number, 0 4; Baltin	city or Town, State, Zi nore ,MD	21207
ore,	Pages 1 ar		20a. Mathod of Disposition  1 Burial 2 Cremation	3X Removal from State ←		esition (Name of matory or other place) Memorial	July	7 6	oc. Location - City or T	
Baltimore,	permit. Pages 1 and 3 Department of Health Important: if itam 27 any injury or other tr. once.		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service )	sensee	207 8	AFA and Addre	she Facility . L	ohrmann F	orozal, Pu P.A.	
8	8258	VI 1	Itylud do	humann	8	717 Green	n Pasture	s Dr., Ba	iltimore, N	MD 21286 Approximate
	Pnysician /Medical Examiner	oj v	23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Low far one cause on each line.  Due to (or as a cons	1 gr			el to L		Interval Between Onset and Death
i.	,365 ,38	Jer	Sequentially list conditions, any late cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	sequence of):					
	ecuted and transit	Examiner	Cause. Enter orderlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a cons	sequence of):					
8760,	cate be executed physician and the burial-transit	dical E		d						
Box 68	certifi nding use as	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre			A	tv	23d. Date of deliv	very
.O. B		Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of		_Ectopic pregnancy _ Other <i>(specify)</i> _			Month	Day Year
0	requires that the een signed by th nould be detache	by Ph	Part II. Other significant condition	as contributing to death but not	resulting in the u	inderlying cause giv	en in Part I.		cco use contribute to	
ord	w requires t been signe should be	ted			-			1 ☐ Yes		
Records,	e ta has je 2	Completed						24a. Was an autopsy performe	prior to c	topsy findings available completion of cause of
Vital	itcian: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					th (Check only one)		
of V	Physician: this certific ral director,	2	1 XYes 2 □ No		ER/Outpatie	III JUDON			ce 6X Other (Spec	at scene
ou c	ding I. After fune	Certification;	27. Manner of Death  1 Natural 5 Pending		28b. Time of Injury	Wor	yat rk? Yes 2. <b>X</b> No	28d. Describe how	I LUIZ I	2001
Division	Attanding r death.	fical	2 Accident investig 3 Suicide 6 Could n	ot be 28e. Place of Injury - A	t home, farm, st	0		28f. Location (Stre	et and Number or Rui	ral Rollte Number,
Div	s after	Serti	4 Homicide determine	building, etc. (Spe		lot		City or Town,		tousville, (4)
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (		g Physician: To the best of my Examiner: On the basis of exam						
	To tha within 3 To tha comple	Me	29b. Signature and title of conflier	111		29c. Licens			d. Date signed (Month	
	1		30, Mame and address of berson	who completed cause of death (	7 C A 100 tem 23a) (Type,	Print				
	5		In DK. ZABIV	um ALI NO	)	111 P€	enn Stree	t, Baltim	ore, Maryl	and 21201
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnapire	parks				

k Indelible Ink. Assure All Copies Are agible. Please Type or Print in P State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Day Year Month Physician JULY JOHN STEVENSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street end number) Examiner TOW SON
If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year) Security Number 6.5 Medical Cen Balto fl Under 1 Year 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 249-22-905 Usuel Residence of Decedent Yrs. Director Peges 1 and 2 should be filed within 72 hours eitar deeth with the Manyland rant of Health and Mentel Hyglene and the file and 27 is marked other than "natural", or items 23s or 28s-f show ant: If item 27 is marked other than "natural", or other traumatic event, its Medical Exempler mat be notified at ury or other traumatic event, its Medical Exempler mat be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Balto Director oseda 10e. Street and Number 10g. Citizen of What Country? U.5A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) tana 10 Funerai 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Stetus Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1□ Yes 2No 21215-0020 Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) rackfore Railroa Sth man altimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HUGLEV Steven SON

19a. Inform: 's Namy relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) R. Stevenson 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Peges 1 Department of H Important: If ite any Injury or ot pnce. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7-7-04 Dundalk mD. Oaklawn Cen 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wesley Chavis Jr F. H 2007 Eastern Ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · CONGESTIVE HEART FAILURE Examiner Due to (or as a consequence of) Examiner KENAL FAILURE or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CORONARY BRYERY 00 12 EDJE Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably A Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 TY95 2 NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Other: 4 | Hospital: 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation → Natural s aftar deeth. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier July 2nd 2004 D0053150 Strong MD 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) CUPYA POBOX 6303 ELLICOTY (17421042 SHARUNMARA

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registra AMEND ITEM #20b PER FH 9833 Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death Year Month 10:09 A 1AMES 2004 JUNE 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town or Location of Death JAMARITAN DALTIMORE 1 Year | If Under 24 Hrs. | 8. Date of Birth Days Hours Min. (Month, Day 9. Birthplace (State or Foreign If Under 1 7. Age (In yrs. last birthday) 5. Social Security Number 1**M**M 2□F 247 · 42 · 3932 Usual Residence of Decedent GEORGIA 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number MIDWOOD AVE. 21212 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: BLACK 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NDUSTRIAL NG SHORMAN 17. Father's Name (First, Middle, Last) UNK. 18. Mother's Name (First, Middle, Maiden Sumame, 9a. Informant's Name/Relationship (Type, Print) Mailing Addr ss (Street and Number of Rural Route Number, City or Town, State, Zip Code) MIDWOOD WIFE ME 20a. Method of Disposition 7.7.04 BAT, MORE, MARKANO 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN C. GREENE FUNERA HOME 21. Signature of Funeral Service Licensee 4905 YORK ROAD BATIMORE, MO 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) aryjod concervito Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify)

Priysician /Medical Examiner

the attending physicien

P.0.

Division of Vital Records,

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page 2 should be detached

certificete has

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Hospitel or Attending P 24 hours after deeth. Funerei Director: After t

24 hours a

To the I within 2

Examiner

Physician/Medical

Completed

Certification:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Hygiene. other then "

permit. Pages I and 2 should be filed with Department of Heelth and Mental Hygient importent: If item 27 is marked other the any injury or other treumetic event, Item 2008.

filed within 72 hours after death

Baltimore, Maryland 21215-0036

the Mudical Extended must be notified at

Director

Funeral

þ

Completed

Be

Sequentially list conditions, if any, leading to immediate cause. Enter this denying Cause (Disease or injury that initiated events resulting in death) Last

26. Place of Death (Check only one)

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

1 Tyes

24b. Were autopsy findings available prior to completion of cause of death?

2 No

9 Unknown

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I

and manner stated.

9 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

27. Manner of Death 1 Natural 2 Accident 5 Pending 3 Suicide

29b. Signature and title of certifier

investigation 6 Could not be determined 4 Homicide

Hospital: 1 ☐ Inpatient 2 ► ER/Outpatient 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28c. Injury at Work?

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

autopsy perform

2 XNo

28d. Describe how injury occurred

29a. Certifier (Check only one)

H0059540

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.0 TERESA MUNS

5601 LOCH RAVER BLUD BAKE MO 21239

Registrar

31. Date filed (Month, Day, Year) JUL 0 2 2004 32 Registrar's Signature

3

State Registrar 31. Date filed (Month, Day, Year)
JUL 0 2 2004

rulla

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sports

OCME

June 30, 2004

111 Penn Street, Baltimore, Maryland 21201

			1 - For State Registrar	State of	Marylan	-	artment rtificate			and M		Reg. No.	004	21013
	Dhysisi		1. Decedent's Name (First, Middle	, Last)							2. Date of D Month	eath Day	Year	3. Time of Death
	Physici /Medio		ERWIN C. S				1				JUNE	30,	2004	5:40 A.M
	Examin		4a. Facility Name (If not institution	, give street and num	nber)				Location of	of Death			unty of Death	
Erwin			OAK CREST CARE						TLLE	24 1150	2.5		BALTIMO	
G.	Funeral		5. Social Security Number	6. Sex 17€27M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Months	Days	If Under Hours	Min.	8. Date of B	ay, Year)		place (State or Foreign intry)
\	Director		216-16-8568 Usual Residence of Decedent		82						9/22/	1921	MAF	RYLAND
N	land		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					·		10d. Inside City Limits
	Maryland -f show	호	MD BALT	IMORE		PARKVI	LLE							1 ☐ Yes 2 ☐ No
5	ith with the Maryla 23s or 28s-f sho	irec	10e, Street and Number				10f. Zip (	Code				10g. Cîtîzer	of What Cou	intry?
3	death with the ms 23a or 28e r.r.ast Le noil	ie D	8800 WALTHER B	LVD. APT.	4201			21	234			US	SA	
	ee EE	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.	Was Decede			gin? (Spe	cify Yes or N Rican, etc.)		Race - Amen Black, White	
~ <b>(</b>	or its	Fu	1 ☐ Never Married 2 🗷 Marr	ied 1 XYes	2 🗆 No		1 Yes 2		Specify:	,	, , , , , ,		ecify:	, 510.
40 4W 5-0036	hours after tural; or its	d by	3 Widowed 4 Divorced		e ates: WWII								WI:	ITE
S % MM S 215-0036	2 2 3	Completed	15. Deceden (Specify only highe	's Education it grade completed)		(Give	dent's Usual kind of work DO NOT use	done of	<i>turing</i> mos	t of workir	ng	16b. Kind	of Business/Ir	ndustry
2	within ene. then	E G	Elementary/Secondary (0-12)	6 YEARS			RTIST			(TVD		FED	ERAL G	OV'T.
/ d 21	0 5 a		17. Father's Name (First, Middle,			A	KITSI	باملد			(First, Middle	e, Maiden Su	mame)	
/o 4 Jand		o Be	CARL G. SCHOL						IREN	IF.	,	WILNER		
/30/04 Maryland	2 should be and Menta is marked sumatic av	은	19a. Informant's Name/Relations			19b. Maili	ng Address	(Street a					own, State, Zi	p Code)
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		NATALIE A. SCH	OLTZ	WIFE	8800	WALTH	ÆR	BLVD.	APT	. 4201	PARKV	ILLE, M	ID 21234
6 Baltimore	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		20a. Method of Disposition		20b. F	Place of Dispo	osition (Nam	e of her plac	a)	D	ate	20c. Locat	ion - City or T	own, State
5	Page lent o nt: If ry or		1 ☐ Burial 2 ②Cremation 1 ☐ Donation 5 ☐ Other (S		סומוט	RO CRE				7/1/	2004	CATO	NSVILL	E. MD
=======================================	mit.		21. Signature of Funeral Service	Licensee	'		2. Name and							HOME, P.A.
ä	Ped Jens		Heathu,	N. Huy	5	8	521 LC	OCH .	RAVEN			WSON,		286
•	Priysician /Medical Examiner	er	23a. Part. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. <u>e. So</u> Due to (	or as a consector as	eal guence of):						tasta	ses	Approximate Interval Between Onset and Death
8760		dical Examiner	cause. Enier underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (d	or as a conseq	uence of):								
P O Box 68	the death cer by the attendir	Physician/Med	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Feta ant at time of c	I death 3	⊒Ectopic pre ⊒ Other <i>(spe</i>					230	l. Date of deliv Month	very Day Year
	w requires that been signed t	ρ	Part II. Other significant condition	ons contributing to de	eath but not res	sulting in the u	inderlying ca	use give	en in Part I			tobacco use ]Yes 2□N		the cause of death?
Nivision of Vital Records	The law re sate has be page 2 sho	Completed								-	24a. Wa auti per 1 ☐ Yes	formed?	4b. Were aut prior to co death? 1 🗌 Yes	opsy findings available ompletion of cause of
=======================================	ician: 1 certifical rector, p	Be	25. Was case referred to medica examiner?					0.1		of Death	(Check only	one)		
7	Physic this c	2	1 ☐ Yes 2 🔀 Ño			ER/Outpatier			4 (2514)				Other (Speci	ify)
\×.	Attanding P death. ctor: After I y the funera	Certification:	27. Manner of Death  1 Sanatural 5 Pendir 2 Accident investi 3 Suicide 6 Could	gation	of Injury h, Day Year)	28b. Time o Injury	of 28	Sc. Injury World	/at k? Yes 2□	No		how injury o		
, <u>i</u>	itel or Att	Certifi	4 ☐ Homicide determ	ined 28e. Place buildir	of Injury - At h	fy)					City or To	own, State)		al Route Number,
	To the Hospitel or Attandi within 24 hours after death. To the Funerel Director: A completely filled in by the tu	ledical	(Check only 2 Medical one)	g Physician: To the Examiner: On the ba and mann	asis of examina	owledge, deat ation and/or in	vestigation,	in my o	pinion, dea	id place, a ith occurre	and due to the	, date and pla	ace, and due t	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifie	r			29c.	License	e number			29d. Date s	igned (Month,	, ∪ay, Year)
			an	monion			-		864			1-1	-04	
	241		30. Name and address of person							oni		2 4		
			31. Date filed (10), Day, Year	Boule 32/R	egistrar's Signa		kuille	1	M	0	212	> 7		
	Sta Regist	ate rar	JUL 022	1004 25	neva	19	Span	Ka	/					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year CHARLENE DALE SCHERZO 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Himore ranklin Mare 05 enter RMa If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 👿 F 53 219~52~2730 March 9,1951 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Baltimore Maryland Baltimore County 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6204 Kenwood Avenue 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes X X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes X2X No Specify: White 3 ☐ Widowed 4 € Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Housekeeping-Own Home 11th grade N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Dieter Shirley Mettam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Scherzo, Jr. (Son) 137 Laurel Woods Court Abingdon, Md. 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 14 ☐ Donation 5 ☐ Other (Specify) 7~3~2004 Baltimore, Md. Oak Lawn Cemeterv 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 21. Signature of Euneral Service Licenses do complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final Dirati disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

or 28e-f ahov

Itams 23e

traumatic evant, the Medical

is markad othar than

Department of Health a Important: If itam 27 is any injury or other tra

Director

Funeral

Completed by

Be

the Marylan

Baltimore, Maryland 21215-003

Examiner burial-transli Physician/Medical use as the þ Be Completed 2 Certification: After after death.

I Diractor: Af
d in by the fur

Division of Vital Records, P.O. Box 68760,

Cause (Disease or injury that initiated events resulting in death) Last	c	juence of):			•
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	Il death 3 Ectopic pres			23d. Date of delivery Month Day Year
Part II. Dther significant conditions	contributing to death but not res	sulting in the underlying cau	use given in Part I.		use contribute to the cause of death?  No 3 Probably 4 Unknown
COPD				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Other: 4 Nursing I	Home 5 Residence	6 Other (Specify)
27. Manner of Death  1 SNatural 5 ☐ Pending 2 ☐ Accident investigatio		28b. Time of 28d Injury M	c. Injury at Work? 1 Yes 2 No	28d. Describe how inju	iry occurred
3 Suicide 6 Could not b 4 Homicide determined		ome, farm, street, factory,	office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
29a. Certifier 1 Certifying P! (Check only one) 2 Medical Exam	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurred at tion and/or investigation, in	the time, date and place n my opinion, death occ	e, and due to the cause(s urred at the time, date an	s) and manner as stated. d place, and due to the cause(s)
205 Circol - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 -		20-	Canada acceptada	201.5	

filled in within 24 hours at To the Funaral C completely filled i

Medical

State

9000 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			State of Maryland / Department of Health and Mental Hygiene  1 - Stata Registrar  Certificate of Death  Rag, No. 0 1 2 1 1 5	-
1	Dhyois	ion	1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death	
	Physici /Medi	cal	MARCELENE 1 1/1 63 DUNE 28 2004 7:5/	M
	Examir	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Toyon, or Location of Death  Ac. County of Death  Ac. County of Death	
	Funeral Director		5. Social Security Number 217 · 10 · 0394  Output  Out	ign
	nyland how		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim	its
	with the Maryland e or 28a-f show Loc notified at	ecto	10e, Street and Number 10f 7in Code 10g Citizen of What Country?	40
	th with	al Dir	2121 E. OUVER STREET  101. Zip Code  21213  102. Citizen of What Country?  U.S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23e or 28a-1 show may night or other treumatic event, the Medical Examinar must be notified at DDCs.	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1	
5-0036	72 hou natura ilgal E		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working)  16b. Kind of Business/Industry	
2121	filed within Hygiene. ther then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)    DomESTIC PRIVATE	
Maryland	ould be fill Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last)  JOHN W. BUTLER  18. Mother's Name (First, Middle, Maiden Symame)  MAR GARET BEOFULD	
	1 and 2 sho Health and I em 27 is me		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  MARCELENE CLERKLEY DAVISHTER 2121 E. OLIVER St. BACTO, MO 21213	
Baltimore	Pages 1 and of He		20a. Method of Disposition  20b. Place of Disposition (Name of cemetary, crematory or other place)  20c. Location - City or Town, State	
altim	permit. Pag Department Importent: I any njury o		*4 Donation 5 Other (Specify) Chrwn Sville Controlly 7.2.04 Chrun Sville Mitches of Facility Variation C. Green's Town Sville Mitches of Town Sville Mitches of Town Sville Mitches On Town Svi	P
ä	Department Important		Vayles free 4905 YORK ROAD BOUTO, MD 21212	
	Physician		23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and disease or condition resulting in death)  a. MY OCARDIAL INFARCTION PROBABLE	1
	/Medical Examiner		Due to (or as a consequence of):  HYPERUL PEM / PERUL PEM /	
	D ::	iner	if any, leading to immediate  Due to (or as a consequence of):	<u></u>
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or influry that initiated events resulting in death) Last  Due to (or as a consequence of):	
8760,	ate be e nysiciar ne buri	dicai E	d	
9		/Med	IF FEMALE: 23b. Was decadent program: 23c. If yes, outcome of pregnancy 23d. Data of delivery	
.O. Box	The law requires that the death certific tie has been signed by the attending r age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	
s, P	ires tha signed b	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?	
corc	w requir been si should	leted	CIGARETIE AISUSE  1AYes 2 No 3 Probably 4 Unknov	
Vital Records,	The law cate has page 2 s	Completed	24a. Was an autopsy findings availab prior to completion of cause of death?  1	10
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 26. Place of Death Check on one)	
of	Phys this	n: To	1   Yes 25 No	_
sion	eath. or: Aft	atio	2 Accident investigation M 1 Yes 2 No	
Division	of or Atlanta din by	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	To the within To the comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
	\ .		3 Amsel MD D16347 712104	
	Ų		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SAMSEL 1000 CATHEDILAL ST BALTIMORE, MD 2120(	
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature  JUL 0 2 2004  Server & Ann K	

Funeral Director

		/land		10a. State	10b. County		10c. City, Tow	n or Location	*				-
		Mary B-f sh iffed	Director	MD	Harford	i E	Bel A	Air					
		r 28,	ie	10e. Street and Nu	ımber			10f.	Zip Code				1(
		th wit	a D	904 Ma	rtel Court	- Unit B			21014				
	36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to C Health and Mental Hygiene. If item 27 is marked other than "natural" or tlems 23a or 28a-f show or other traumatic event, the Medical Examinational by myllind at	by Funeral		ried 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			cedent of Hi pecify Cuba 2X No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yerto Rican	'es or No- , etc.)	
	Ş	tural	edt		15. Decedent's Edu		16a	. Decedent's U	sual Occupa	ation			
	Baltimore, Maryland 21215-0036	within 72 iene. than "ne	Completed	(Spe Elementary/Sec 12		e completed) College (1-4or 5+		(Give kind of life, DO NO)	work done d use retired	turing most of v	working		
	2	filed v Hygie other t	ပိ		(First, Middle, Last)			Cashie	<u> </u>	18. Mother's h	lame (Firs	t Middle	A
	ylano	and 2 should be i eaith and Mental I n 27 is marked o ier traumatic eve	To Be		Dettor,	Jr.				June 1			
1	<u>a</u>	2 sho and is my		i .	lame/Relationship (Ty		19t	o. Mailing Addre	ess (Street a	and Number or	Rural Rou	te Numbe	r,
2	≥	l and 2 lealth a m 27 i			sa Hall (da	ughter)				ck Drive		el Ai	L
	ore	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Dis	sposition   Cremation 3 PF	Removal from State	20b. Place o	of Disposition (form, crematory of	Name of or other plac	θ)	Date		2
5	Ë	Pa In the Indian			5 Other (Specify)		Morela	and Memo					
	Salt	permit. Pa Departmen Important: any injury		21. Signature of F	uneral Service Licens	90				s of Facility			
)	ш	₫ Ω <u>=</u>		10.	I. Ja					r Road			_
			******	23a. Part1. Enter shock, or he	the disease, or compl art failure. List only or	ications that caused t ne cause on each line	he death. Do	not enter the m	node of dyin	g, such as card	liac or resp	oiratory ari	re
	,	Physician		Immediate Cause disease or conditi	ion ,	CHRON	110 02	STAU CT II	IE PJ	LMON	MAY	Dis	ť
•		/Medical Examiner		resulting in death)		Due to (or as a	consequence	of):					
		Examiner		Sequentially list of	onditions.	o							
	IX	p #	ine	if any, leading to i cause. Enter Und Cause (Disease o	mmediate lerlying	Due to (or as a	consequence	of):					
	On	ecute and trans	Examiner	that initiated event resulting in death)	is 🔳 (	C		-6					_
	90,	De ex	<u> </u>	roodking in doubly		Due to (or as a	consequence	or):					
	876	hysic the b	dica			d							-
	9 ×	ertific ding p	/Me	IF FEMALE:	1	12a If you guttaama a	f programmy						
	Records, P.O. Box 68760	ne death o the attend thed for us	by Physician/Medical	23b. Was deceded in the past 12 1 Yes 2 9 Unknown	2 months?	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death	3 □Ectopio 5 □ Other	pregnancy (specify)	-			
	σ.	that the	P.		ificant conditions con	ntributing to death but	not resulting i	n the underlyin	a cause dive	en in Part I.	2	23e. Did to	b
	ords,	aquires t en signe buid be (	ted by						9 00000 917		_	JE Y	
	Reco	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed			did di					-	24a. Whas a autop: perfor ☐ Yes	S
	ital	ian: rtifica stor, p	O	25. Was case rete	erred to medical					26. Place of [			76
	<b>&gt;</b>	nysic nis ce direc	To B	examiner?	No F	lospital: 1 🗌 Inpatien	t 2 ER/O	utpatient 3	DOA Othe	er: 4 🗆 Nursin	g Home	5 Resid	9
	o uoi	nding Pt th. : After the funeral		27. Manner of Dea Natural 2 Accident	ath 5 Pending investigation	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury M	28c. Injury Work	at ⟨? Yes 2 □ No	28d. C	escribe h	0
	Division of Vit	l or Atter after dea Director	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, fa (Specify)	arm, street, fac	tory, office		28f. L	ocation (S lity or Tow	tr
		To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely illied in by the funeral director,	Medical C	29a. Certifier (Check only one)	Certifying Phys	sicien: To the best of ner: On the basis of and manner stat	examination ar	e, death occurr nd/or investigat	ed at the timion, in my of	e, date and pla pinion, death or	ace, and de courred at	ue to the c	a
		o the ithin o the omple	Me	29b. Signature and	d title of certifier	and manner stat			29c. License	number		- 2	25
		F ≯ F ŏ		NIR	hos	~D			Dooss	034			
		15		30. Name and add	dress of person who co	ompleted cause of de	ath (Item 23a)	(Type, Print)					-
		1.	1	1 3 //	O C. 11 . *	V - 1				1		-1 3	

		State of Maryland / Departm	nent of Health and Micate of Death		2001	21016
2		Registrer  1. Decedent's Name (First, Middle, Last)	Cate of Beatiff	2. Date of Death	. No. 2 U ! J ! !	3. Time of Death
Physicia /Medic		Constance M. Traband		June 2	29, 2004	6:00 PM M
Examin		, , , , , , , , , , , , , , , , , , , ,	. City, Town, or Location of Death		4c. County of Dea	th
			Bel Air		Harford	
Funeral Director			Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Y 08/31/19		thplace (State or Foreign ountry) aryland
		Usual Residence of Decedent		00/51/15	17 11	-
show	-	10a. State 10b. County 10c. City, Town or Locatio	on			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
28a-f	Director	MD Harford Bel Air	01 7:- O-1-	10-	. Citizen of What Co	
a or		904 Martel Court - Unit B	Of. Zip Code 21014			ountry !
ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	U.S.A. 14. Race - Ame	
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Menti arked	2	Frank L. Dettor, Jr.		Prender		
hand 7 is m traum			ddress (Street and Number or Run		•	, ,
Department of Health and Mental Hygiene important; or flems 23a or 28a-f show important: if item 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition 20b. Place of Disposition	linklock Drive		c. Location - City or	
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ysician		Immediate Cause (Final disease or condition resulting in death)	IVE PULMONA!	zy Dist	NE	10 YEARS
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tor: A	cati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	006 1 (Chara	-A	-12-11
Direc in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	City or Town, S	et and Number or Ri State)	ural Houle Number,
neral rilled		29a. Certifier Certifying Physicien: To the best of my knowledge, death occ	curred at the time, date and place,	and due to the caus	se(s) and manner as	s stated.
within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigand manner stated.	gation, in my opinion, death occurr	red at the time, date	and place, and due	o to the cause(s)
To t	M	29b. Signature and title of certifier	29c. License number		. Date signed (Mont	
		Jehry, mo	D0035034		6/30/0	Y
15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print )	PRIVE SUITE 311	BFL AIR	. MD 21	014
Sta	te	31. Date filed (Mopth, Day, Year)  32. Registrar's Signature	/	1	1	
Registr		JUL UZ 2004 Degue &	rocks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** VanDaniker , Sr. William Leo June 30, 12:10 ₽<sup>M</sup> 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Co. Dundalk 7455 Manchester Road 8. Date of Birth (Month, Day, Year) Feb. 16,1936 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days Hours 1 **M** 2 □ F 68 Maryland 213-32-4747 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County ral', or items 23a or 28a-f show Examinat must be notified at Dundalk Baltimore 1 ☐ Yes 2X No Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 7455 Manchester Road United States death v by Funeral 12, Was Decedent Ever in U.S. Armed Forces? bayes 2 □ No If Yes, Give Year or Dates: 1958-63 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: 3 Widowed 4 Divorced White natural', Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry Crane Operator 12 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) f Health and Mental Hitem 27 is marked otlother traumatic even Be Sarah M. Neary George E. VanDaniker ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wife 7455 Manchester Road Dundalk, Maryland 21222 Mrs. Catherine E. VanDaniker item 27 i Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition to = 0 P⊆Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Sacred Ht. of Jesus Cem. 7/3/3004 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee permit. 22. Name and Address of Facility
Lau a-Ruck Funeral Home of Dundalk, Inc. Part 1. Enter the disease, or complications that caused the deaths shock, or heart failure. List only one cause on each line. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death ot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) LUNCE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (USease or in jury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical the the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. the 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 3 ☐ Probably 4 ☐ Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 🗆 No 1 Yes certificate 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Sesidence 6 Other (Specify) Hospital: P 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: After Injury 5 Pending Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 040854 613012004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 21202 Phychory arid MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUL 0 2 2004

			1 - For Amend Item 2 Registrar	6 State of Ma	C839,67/02 Cei	ytmantof He tificate of C	ealth and M Death	lental Hyg	iene eg. No. 00 L	21018
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	Funeral Director			M 20XF	37 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1-13-		Country) Md
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	nyland how		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
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	ath w	ral	6681 Spring Mi			21207		- V - V N		A
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene tem "netural", or items 23a or 28e-1 show other tream "netural", or items 23a or 28e-1 show other treumatic event, the Medical Examination and other treumatic event, the Medical Examination at	by Funeral Director	11. Marital Status  1 ⚠ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent & Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	lo	Was Decedent of His f Yes, specify Cuban I □ Yes 2X No	panic Origin? (Spi , Mexican, Puerto Specify:	Rican, etc.)		American Indian, White, etc. Black
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and	be fill hall H bd otl	Be	17. Father's Name (First, Middle, Last) John Williams				18. Mother's Name			
ž	hould d Mer mark mark	으	19a. Informant's Name/Relationship (	Type Print)	19h Mailie	ng Address (Street ar		ine Pric		te Zin Code)
Maryland	d 2 s th an t7 is r				6681	Spring Mi			-	
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Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if Item 27 is marked other than any injury or other treumatic event, Item 2006.		21. Signature of Funeral Service Licer			. Name and Address		March F/		didei oo. iid
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	o the o the o mplk	Me	29b. Signature and title of pertiner			29c. License	number	2	9d. Date signed (A	Month, Day, Year)
	F > F 0		W. Cal		AL LA	Doo	19419		JUNF 3	2004
	0		30. Name and address of person who	completed cause of a	eath (Nem 23a) (Type,	Print)	\ \	)	- KI- C )(	0,000.
	$\wedge$		DIANA H. (c	RIFETA	1900	ATON +	WE. I	AKTHO	EE, MD	21339
	Sta		31. Date filed (Month, Day, Year)	22. Registra	ar's Signature	ach			,	
	Regist	ar	JUL 0 2 2004	1	/ //					

Samuel Bryant Wilson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-03995 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar RJ Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) June 17, Day 2004 0158 P.M **Physician** Samuel Wilson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner Baltimore 4820 Greencrest Road If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year, Mar 30, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 212-36-1753 65 1939 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiens, till filem 71 the family and marked other than "naturel", or Itams 23a or 28e-1 ehow marked or than than "naturel", or Itams 23a or 28e-1 ehow may or other treumetic event, the Maxical Examt naturely be natified at ury or other treumetic event, the Maxical Examt naturely. MD Baltimore 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4820 Greencrest Road 21206 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filled within 72 hours after a and Mental Hygiene.

Is marked other than "naturel, or Ital 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: black ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) unk College (1-4or 5+) unk 1ongshoreman Port of Baltimore 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Samuel Wilson Clotie Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dolores Wilson/spouse 4820 Greencrest Road Baltimore, MD 21206 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or <sup>1</sup> 4 ∑Donation 5 ☐ Other (Specify) S. Wade State Anatomy Board 655 W. Baltimore Street baltimore, MD 21201 21. Signature of Funeral Service etor Baltimore, MĎ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, br heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hypertensine atheroselenste cadanasular disease Immediate dause (Final disease or condition resulting in death) Pnysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 Yes 1 XYes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6X Other (Specify) Hospital: Scene 1 Inpatient 2 ER/Outpatient 3 DOA 2 1XYes 2 No this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27, Manner of Death Certification:

To the Hospitel or Attending Physician: funeral dir After s after death. filled in by within 24 hours a To the Funaral E

1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

OCME

June 18, 2004

Jaska? Greensing

30. Name and address of person who completed caused death (item 23a) (Type, Print) Penn Street, Baltimore, Maryland 21201 M.D lasha Z Greenberz

31. Date filed (Month, Day, Year)

032. Registrar's Signature

JUL 0 2 2004

Medical

State

Registrar

			For S    Sequenter   Sequenter	tate of Maryland		artment o				giene Reg. N		2102	
	Physici		Negistral     Decedent's Name (First, Middle, Last)     BENJAMI	N		BROTM	-		2. Date of De	ath	004 Year	3. Time of D	eath AM
	/Medic Examir		4a. Facility Name (If not institution, give stree HOSPICE OF BALTIMORE	et and number)	ENTER	4b. City, To	wn, or L	ocation of E	Death		County of Death		
	Funeral Director		5. Social Security Number 217-03-0520 6. Sex	7. Age (In yrs. las		If Under 1 \ Months D		If Under 24		th Year)	9. Birth	place (State or F intry) MD	Foreign
	aryland show	J.	Usual Residence of Decedent  10a. State 10b. County  N/A	10c. City, 1		cation I MORE	_					10d. Inside City	
	with the M a or 28e-f	Director	10e. Street and Number 2823 W. STRATHMORE	AVENUE	DALI	10f. Zip Co	ode	21209		10g. Cit	izen of What Cou		
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Boltimor	permit. Pages 1 Department of F Importent: If ite any injury or ot once.		1 🎇 Burial 2 □ Cremation 3 □ Rem  '4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	BETH	EL M	EMORIA	L PA	ARK 7	/5/2004 SOL LEVIN		NDALLSTO & BROS		_
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	this ald	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1   Inpatient 2   El	R/Outpatier 8b. Time of Injury	nt 3 DOA f 28c	Othe	r: 4 □ Nurs	f Death (Check only ing Home 5 Res	idence	6 Other (Specify occurred	eity) Hosp	a ce
AMILY Division	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, st	reet, factory, c	office		28f. Location ( City or To		nd Number or Ru e)	ral Route Numbe	er,
SHIP.	the Hospi hin 24 hou the Funer npletely fil	Medical	(Check only 2 Medical Examiner one)	an: To the best of my knowl : On the basis of examinatio and manner stated.	edge, deat on and/or in	vestigation, in	n my op	e, date and inion, death number	place, and due to the occurred at the time,	dato an	) and manner as d place, and due tte signed (Month	to the cause(s)	
D	To wit		29b. Signature and tive of certifler	my Rily	in				les St.				
	5	ate	30. Name and address of person who comp 31. Date filed (Month, Day, Year)	32. Registrar's Signatu	670	5/ N	· C	lan	les St.	Bo	Bro. n	nd 21.	20%
	Regist		1777 A & 200 A	Leneva	4	1:	-	,				1	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day **Physician** Joseph G. Balog June 30, 2004 9:25 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 213-52-8853 50 Yrs Director 30. 1954 Maryland Usual Residence of Decedent the Maryland 10b. Count 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-1 show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director MD Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with theath and Mental Hygiene. Heath and Mental Hygiene. Sem 27 Ia marked other than "natural", or Items 23a or 2 2104 Folkstone Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Senior Technician Swisslog Translogic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Michael A. Balog Viola Wisniski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit Pages 1 and 2.
Department of Health as important: if item 27 Is any injury or other traugunes. Deborah R. Balog wife 2104 Folkstone Road; Lutherville, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Parkwood Cemetery ¹ 4 ☐ Donation 7/6/04 5 ☐ Other (Specify) Parkville, MD Funeral Service Licens 21. Signature of 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Massive Physician 10ms disease or condition resulting in death) /Medical Due to (or as a consequence of) Movithis Examiner UNG (anu Sequentially list conditions Dualto for as a posecuence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ director, page 2 should be 1 Nes 2 □ No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan certificate has 2 No 1 Yes 25. Was case referred 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 R/Outpatient 3 TI DOA this 27. Mann to \_ 28c. Injury at Work? of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funeral D 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 2001 0 and address of person who completed cause of death (Item 23a) (Type, Print) 13-MD 6701

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUL 0 6 2004

Salog, Joseph

sports

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) : 49PM Year Physician 2004 01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HO timore na If Under 1 Year If Under 24 Hrs. 8. Date of Birth
House Pays Hours Min. (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 1 F Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State item 27 is marked other then "naturel", or items 23e or 28e-1 show other treumatic event, the Medical Expression in the religious 1 Pres 2 □ No NIP MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 2302 USA Swego Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: Black 3 Widowed 4 □ Divorced Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) latah Alice Dixon Elementary/Secondary (0-12) College (1-4or 5+) Drug Store 18. Mother's Name (First, Middle, Maiden Sumame) Father's Name (First, Middle, Last) Braxton ackson liûm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balto. Oswego 2302 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Daurial 2 ☐ Gremation 3 Removal from State njury or Men. rbutus Other (Specify) ↑ 4 □ Donation 21. Signature of Juneral Service Licenses 22. Name and Address of Facility 21229 any reaniton fass Balto, mo r. Illarch d mon 23a. Part. In of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, rear failure. List only one cause on each line. Approximate Onset and Death Immediat ause (Final disease or condition resulting in death) 0515 **Physician** dar /Medical Due to (or as a consequence of): Examiner blee Sequentially list conditions Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physician and for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has certificate 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 ☑ No 6 ☐Other (Specify) 1 y npatient 2 ER/Outpatient 3 DOA 5 Residence 2 this 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: within 24 hours after death. To the Funerel Director: After 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

3

31. Date filed (Month, Day, Year) JUL 0 6 2004

word

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Kourissa

anna



	_		1 - For State Registrar	State of I	Maryland		artmen rtificat			and M		Reg. No.	104	21023	
	Physici	an	Decedent's Name (First, Middle,		2 /						2. Date of De Month	Day	Year	3. Time of Death	
	/Medic		DORA		BAYLU	7	41. 01.	T	Location	4 D 4 h	JULY	3	2004 unty of Death	1257 PM	
7	Examir	er	4a. Facility Name (If not institution,		9r)				Location o				AL7 ( mo		
	Funeral			Sex 7.	Age (In yrs. la	ast birthday)	, ,	1 Year	If Under	24 Hrs.	8. Date of Birt	h	9. Birth	place (State or Foreign	
	Funeral Director		162-26-7899	1 □ M 2 □X	93		Months	Days	Hours	Min.	Feb 23	y, Year) 1911	Cou	land	
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	arylar show	<u>_</u>	10a. State 10b. County		10c. City	, Town or Lo								10d. Inside City Limits	
	Be-13	Directo	Maryland N/A			_Balt	imore							X□Yes 2□No	
	with th	Ö	10e. Street and Number	"-			10f. Żip		<del>-</del>				of What Cou	ntry?	
	s 23g	Funeral	3805 Clarks Lan	e #B 12. Was Decede	ent Ever in III	2 12	Was Doon		215	ain? (Sne	oity Voc or No		SA Race - Ameri	ican Indian	
	item item	Į.	11. Marital Status 1 □ Never Married 2 □ Married	Armed Force	s?	3.	If Yes, spec	cify Cuba	n, Mexicar	i, Puerto	cify Yes or No Rican, etc.)	14.	Black, White,		
39	ali, or	by	3x Widowed 4 □ Divorced	If Yes, Give Year or Date			1 🗌 Yes	<b>№</b> No	Specify:			Spe	ecify: W	hite	
Ö	J within 72 hours after death with the Maryland jiene. r then "naturel", or Items 23a or 28e-f show the Medical Ezandar mout be notified at	Completed	15. Decedent's	Education			dent's Usua kind of wo			t of worki	20	16b. Kind o	of Business/Ir	ndustry	
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o.		Jys	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unknow	n										
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rds	w require been sig should b										1 🗆 '	Yes 2□N	o 3□Prol	bably 4 Unknown	
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	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: Afte completely filled in by the fune	Med	29b. Signature and title of certifier	and manner	Jiaidu.		290	c. License	number			29d. Date sid	gned (Month,	Day, Year)	
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	is		30. Name and address of person w	no completed cause		23a) (Type	Print)	10	059	156	/	1-4	> (	4	
	(		DEBORAH WATS			RT HWE		1405	PITAL	52	101 OL	D COUR	T RO.	40	
	Sta	ate	31. Date filed (Month, Day, Year)		istrar's Signat								***************************************		
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		1 - For State Registrar		Marylar		artmen rtificate			and M		Reg. N	2111	) 4	210:	24
Physicia /Medic Examine	al	Decedent's Name (First, Middle, L     Mary Belagyi      4a. Facility Name (If not institution, g		ber)		4b. City,	Town, or	Location o	of Death	2. Date of De. Month July 4	, 2	.004 c. County	Year of Death	3. Time of 8:00	
Funeral Director		220-14-1301	Sex 1□ M 2√xF	7. Age (In yrs. 81	last birthday) Yrs.	Tov If Under Months	VSON 1 Year Days	If Under	24 Hrs. Min.	8. Date of Birl (Month, Da 8/25/	192		9. Birthr Cour Bal	ce place (State on ptry) Ltimore	r Foreign
the Maryland 28a-f show	ector	Usual Residence of Decedent  10a, State 10b, County  MD  10e, Street and Number			ny, Town or Lo	re	0.1		-					0d. Inside Cit	-
	Funeral Director	3216 Hudson Str  11. Marital Status  1 Never Married 2 Married	12. Was Dece Armed For 1  Yes	ces? 2 [X] No		Was Deced	2122 ent of Hi ify Cuba	spanic Ori n, Mexican	gin? (Spe	ocify Yes or No Rican, etc.)		U.S 14. Rac Blac	e - Americ ck, White,	ean Indian,	
thin 72 hours a e. an "natural", c. Medical Exar	Completed by	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's (Specify only highest g  Elementary/Secondary (0-12)	If Yes, Give Year or Da Education rade completed)  College (1-	tes:	16a. Dece (Give life.	dent's Usua kind of woi DO NOT us	l Occupa	turina mosi	t of workii	ng		Kind of Bu	/: Whit	dustry	
Mental Hygier Mental Hygier arked other th	To Be Cor	10 17. Father's Name (First, Middle, Las George Scharf	st)		Sa	ales				(First, Middle, es Murp					
es 1 and 2 sho of Heelth and 1 litem 27 is mar rother treum		19a. Informant's Name/Relationship  Susan Williams/  20a. Method of Disposition	Daughter	20b. F		9 Chi	penl	ham D	rive		er, City or Town, State, Zip Code)  Maryland 20723  20c. Location - City or Town, State				
permit. Pages Department of Importent: if it any injury or o once.	,	1 ☑ Bunial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Service Lice)  21. Signature of Funeral Service Lice	cify)	late	cred He	eart (	of Jod Addres	esus	y Bra	04 dley-As Road Du	hto	n-Ma	tthev		
Physician /Medical Examiner /Me pnuial-transit	Examiner	23a. Part   Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Immediate Cause (Final disease or condition resulting in death)  Approximately a consequence of conditions of any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):													veen
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To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer	edical Cert	29a. Certifier 1 Certifying F	Physician: To the taminer: On the bar and manner	sis of examina	owledge, death	n occurred a	at the tim in my op	e, date and inion, deat	d place, a	nd due to the od at the time, of	rausels	em bne (a	nner as st	ated. the cause(s)	
To the Withir To the comp	Me	29b. Signature and title of certifier  30. Name and address of person who	my Ni	ly:	UND				5					Day, Year)	
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Delayge, MALY July 4, 2004, 0820

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ZO: 43 PM Elizabeth 06 2004 Booklage 24 /Medical Facility Name (If not institution, give street and n 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medical Cft. Baltimore Hopking N/A Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 ☐ F Yrs. Director 216-09-9888 86 NOV. 12, MD. Usual Residence of Decedent the Manyland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State item 27 is marked other than "naturel", or Items 23a or 28a-1 show other treumatic event, the Medical Examples must be notified at tv□Yes 2□No Director BALTIMORE MD. N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 6816 FAIT AVENUE 21224 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 T No If Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yeo Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry iled within at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental H should be ANTHONY BRAZIS MARY VZANARIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Importent: If item 27 Is m any injury or other treum once. 6816 FAIT AVE., BALTIMORE, MARYLAND 21224 CASPER J. BOCKLAGE, JR./SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State HOLY REDEEMER CEMETERY 6/29/04 BALTIMORE, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 3-100 essur 23a. Pai 1 Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shiply or heart failure. List only one call in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical as a consequence of) **Examiner** Aspiratia Phennouia Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical as the l IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death in the past 12 months? Month Day Year ō 4□Pregnant at time of death 5 Other (specify) o the detached 9 Unknown 9 Unknown á ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, pe 1 Yes 2 To 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas page 2 autopsy perform certificate 2 0 No Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 Natural 1 🔲 Yes 2 II No death. after death 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 T Homicide within 24 hours a To the Funerel C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES - 001 O e and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hophins Bergina Hedical Center, 4940 Faster Av. 21224 State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

	an	1. Decedent's Name (First, Midd William Lee	<sup>He, Last)</sup> <b>Wil</b> Broughma	liam l	Lee	Broug	hman				2. Date of De Month JULY	eath	3 2004	3. Time of Death 4:45 A
/Medic Examin		4a. Facility Name (If not institution Atlantic Gene						ty, Town, or Berlin		of Death		40	County of Dea	ath
Funeral Director	9	5. Social Security Number 219-80-2442	6. Sex 1X M 2	_	(In yrs. 1:	ast birthday Yrs.	/) If Und Month	der 1 Year s Days	If Under Hours	Min.	8. Date of Bi (Month, Di 2/13/	rth <i>ay, Year,</i> 196]	9. Bi	rthplace (State or Foreign Country) aryland
Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. Count  MD N	/A			, Town or L Baltin								10d. Inside City Limit
with the 3s or 28s	Funeral Director	10e. Street and Number 1345 Broening	Highway			· · · · · ·	10f. 2	Zip Code	24			10g. Ci	itizen of What C	
be filiad within 72 hours after death with the Maryland ital Hygiena. Id other than "neturel", or Items 23s or 28a-f show evant. Ite Medical Exstulibrations the medical exercitation.	by	11. Marital Status  1 Never Married 24 Ma 3 Widowed 4 Divorce	rned 1+1Y	Decedent Evd Forces?  'es 2 □ Nos, Give or Dates:		S. 13.		cedent of H pecify Cuba 212 No	ispanic Oi in, Mexica Specify		ecify Yes or No Rican, etc.)	0-	14. Race - Am Black, Whi Specify: W	ite, etc.
c 2 0	Completed	15. Decede (Specify only high Elementary/Secondary (0-12) 12	1	ted) ge (1-4or 5+	)	(Give	e kind of v DO NOT	sual Occupa work done of use retired	during mo: f)	st of work	ing		Kind of Business	,
2 should be filad within and Mental Hygiena. Is marked other than aumatic evant. If E.M.	To Be Co	17. Father's Name (First, Middle	, <sup>Last)</sup> <b>Will</b> Oghman S	iam L.	. Br				18. Moth		(First, Middle Addick	, Maider		Lation
and 2 should be faith and Mental H		19a. Informant's Name/Relation Rickey L. Bro											or Town, State, Maryla	Zip Code) and 21224
permit. Pages 1 and 2 should b Department of Health and Menta Important: If Itam 27 is marked any injury or other traumatic e once.		20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other (	Specify)	rom State	Ce	lace of Disp emetery, cre rdens	of I	rotherplac Taith		7/7,		Ba1		Maryland
permit Depar Impor any in		21. Signature of Funeral Service	Licensee										iler&sor	n, Inc. Land 21224
	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Extra Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  c.  Due to (or as a consequence of):  d.  IF FEMALE:  23c. If yes, outcome of pregnancy												
at the death certific by the attending p tached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Live birth 2   Fetal death   5   Other (specify)   9   Unknown   9   Unknown   9   Unknown   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   Month   1   Livery   Month   1   Livery   1									livery Day Year			
es ti igna	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.						23e. Did t		1	o the cause of death?				
The ate ha	Completed										24a. Was auto 1 Yes	an psy ormed? 2 \( \text{No.}	prior to death	utopsy findings available completion of cause of
hysic his c	ation; To Be	examiner? 1 ZYes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 I						28c. Injury at Work? 28d. Describ				dence	6 □ Other (Sperry occurred	ocify)
itel or Attanc ins after death raf Diractor: led in by the i	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							2	28f. Location ( City or To	Street an wn, State	nd Number or Ri e)	ural Route Number,	
To the Hospitel of within 24 hours af To the Funeral D completely filled in	edicai	29a. Certifier 1 ☐ Certifyi (Check only one) 2 ☐ Medica	ng Physician: To Examiner: On the and n	the best of ne basis of e manner state	xaminati	vledge, deal ion and/or ir	th occurre nvestigation	d at the tim on, in my op	e, date ar inion, dea	nd place, a ith occurre	and due to the ed at the time,	cause(s) date and	) and manner as d place, and due	s stated. a to the cause(s)
To tha within 2 To tha comple	Σ	29b. Signature and title of certific	5 Done	You	e	my	2	9c. License	number O.C.N	1.E.			te signed (Mont $y 04$ , 20	
	-	1.0												

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	5. S248-02-7388 248-02-7388 Usual Residence of Decedent 10a. State 10b. County	PT#1308  12. Was Deceden Armed Forces 1	ge (In yrs. last birthday, 80 Yrs.  10c. City, Town or LINMAN  t Ever in U.S. 13.	4b. City, Town, o T IMON I UM If Under 1 Year Months Days  coation  10f. Zip Code 29349  Was Decedent of H	ti Under 24 Hrs. Hours Min.  Hispanic Origin? (Span, Mexican, Puerto	2. Date of Death Month 07  8. Date of Birth (Month, Day, MARCH 16.	Day You O2 200 4c. County of BALT III Year) 9 1924  Og. Citizen of What UNITED STA	Death MORE Birthplace (State or Fore Country) SOUTH CAROLINA  10d. tnside City Lim 1  Yes 2  1			
	4a. Facility Name (If not institution, ging STELLA MARIS 230  5. Symbology Ny 388  246.66.7368  Usual Residence of Decedent  10a. State 10b. County SC SPART  10e. Street and Number PLEASANT MEADOW A  11. Marital Status  1 Never Married 2 Married 3 Ny Vidowed 4 Divorced  15. Decedent's E (Specify only highest gridle) Elementary/Secondary (0-12) 6	DULANEY V/ Sex 7. A  1 M 2 F  ANBURG  PT#1308  12. Was Deceden Armed Forces 1   Yes 2 F If Yes, Given Y year or Dates ducation ade completed)	ALLEY RD  ge (In yrs. last birthday, 80 Yrs.  10c. City, Town or L I NMAN  t Ever in U.S. ?	TIMONIUM  If Under 1 Year  Months Days  Docation  10f. Zip Code  29349  Was Decedent of H If Yes, specify Cubs	ti Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, MARCH 16.	02 200  4c. County of BALT II  Year) 9 1924  Og. Citizen of What	Death MORE  Birthplace (State or Fore Country)  SOUTH CAROLINA  10d. triside City Lim 1  Yes 2  1			
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	10a. State SC  10b. County SC  10c. Street and Number  PLEASANT MEADOW A  11. Marital Status  1 Never Married 2 Married 3 Novidowed 4 Divorced  15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 6	PT#1308  12. Was Deceden Armed Forces 1   Yes 2   If Yes, GiveA Year or Dates  ducation ade completed)	I NMAN  t Ever in U.S. 13.	10f. Zip Code 29349 Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	UNITED STA	10d. tnside City Lim  1  Yes 2 XX at Country?			
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ne completed by I diletar	10e. Street and Number  PLEASANT MEADOW A  11. Marital Status  1 Never Married 2 Married  3 Note of the state	12. Was Deceden Armed Forces 1 ☐ Yes 2 It Yes, GiveX Year or Dates ducation ade completed)	t Ever in U.S. 7, No.	29349 Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	UNITED STA	at Country?			
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ם י	(Specify only highest gr. Elementary/Secondary (0-12)	ade completed)	16a. Deca		Specify:	Rican, etc.)	Specify:	White, etc.			
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ם י			life	DO NOT use retired	during most of work	irig					
a 1	17 Father's Name (First Middle Last		HOU	SEKEEPER			DOMESTI	С			
	The date of the transfer of th	)			18. Mother's Nam	e (First, Middle, M	laiden Sumame)				
	HAROLD LYNCH										
		Type, Print)						te, Zip Code)			
-								y or Town State			
1	1XXBurial 2 ☐ Cremation 3X		cemetery, cre	matory`or other plac	ce)						
1						8, 2004	WEELFORD,	SC			
1	KELLY CRECORY FY	NK	M01148 42	6 CRAIN HWY	SW GLEN BU						
	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b. Due to (or as	s a consequence of): s a consequence of):								
by rilysiciallyme	ב ב	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  yes 2  No 9  Unknown X	1 Live birth	2 Fetal death 3		,		23d. Date of Month	delivery Day Year		
		<u>ה</u>	2	ב ב		Part II. Other significant conditions (	contributing to death	but not resulting in the u	nderlying cause give	en in Part I.	
_						autopsy perform	ed? prior	autopsy findings availa to completion of cause			
					26. Place of Death	n (Check only one	)				
2	1 ☐ Yes 2√√ No 27. Manner of Death	28a. Date of Inj (Month, Da	ury 28b. Time o	28c. Injury Work	at k?		427	Specify) PDSPICE			
	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of In	jury - At home, farm, str tc. (Specify)					r Rural Route Number,			
	29a. Certifier (Check only one)  1   Certifying Pf 2   Medical Exar	niner: On the basis of	or examination and/or in	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occurr	and due to the cau ed at the time, dat	use(s) and manne e and place, and	r as stated. due to the cause(s)			
	29b. Signature and title of certifier			29c. License	e number	290	d. Date signed (M	onth, Day, Year)			
		60-		1)6	73725			,			
-	30. Name and address of person who	completed cause of	death (Item 23a) (Type	Print)			.,, 02, 2004				
1					NIUM. MD 21	093					
		HAROLD LYNCH  19a. Informant's Name/Relationship ( FLORENCE BROWN  20a. Method of Disposition  1X Burial 2	HAROLD LYNCH  19a. Informant's Name/Relationship (Type, Print)  FLORENCE BROWN  20a. Method of Disposition  1XXBurial 2	HAROLD LYNCH  19a. Informant's Name/Relationship (Type, Print)  FLORENCE BROWN  20a. Method of Disposition 1X Burial 2 Cremation 3XXRemoval from State 4 Donation 5 Other (Specify)  21. Signature (Fuheral Service Lisenses)  KELLY CRECORY NNK  MO1148  42  23a. Part1 Enter the disease, of complications that caused the death. Do not entered shock of heart failure. List baily one cause on each line.  Immediate Cause (Final death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Libesse of Trigury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of)	HAROLD LYNCH  19a. Informant's Name/Relationship (Type, Print)  FLORENCE BROWN  FLORENCE BROWN  1917 CRESTVIE  20a. Method of Disposition (Name of cemetery, crematory or other place of Disposition (Name of cemetery, crematory) or other place of Disposition (Name of cemetery, crematory) or other place of Disposition (Name of cemetery, crematory) or other place of Disposition (Name of cemetery, crematory) or other place of Disposition (Name of cemetery, crematory) or other place of Disposition (Name of cemetery, crematory) or other place of Disposition (Name of cemetery, crematory) or other place of Disposition (Name of cemetery, crematory) or other place of Cemetery, crematory or other place of Cemetery, cre	HAROLD LYNCH  19a. Informant's Name/Relationship (Type, Print)  FLORENCE BROWN  20a. Method of Disposition  10x Reurial 2 Cremation 3x Removal from State  1 Donation 5 Cither (Specify)  21. Signatury Fibrara Service Lysinses  KELLY CRECORY (NK  MO1148  22. Name and Address of Facility FINK FUNERAL HOME, P. A.  KELLY CRECORY (NK  MO1148  426 CRAIT HOME, P. A.  KELLY CRECORY (NK  MO1148  426 CRAIT Home and Address of Facility FINK FUNERAL HOME, P. A.  KELLY CRECORY (NK  MO1148  A L26 CRAIT Home and Address of Facility FINK FUNERAL HOME, P. A.  KELLY CRECORY (NK  MO1148  426 CRAIT HOME, P. A.  KELLY CRECORY (NK  MO1148  A L26 CRAIT Home and Address of Facility FINK FUNERAL HOME, P. A.  KELLY CRECORY (NK  MO1148  A L26 CRAIT HOME, P. A.  KELLY CRECORY (NK  MO1148  A L26 CRAIT HOME, P. A.  KELLY CRECORY (NK  MO1148  A L26 CRAIT HOME, P. A.  KELLY CRECORY (NK  MO1148  M L26 CRAIT HOME, P. A.  KELLY CRECORY (NK  MO1148  M L26 CRAIT HOME, P. A.  KELLY CRECORY (NK  MO1148  M L26 CRAIT HOME, P. A.  KELLY CRECORY (NK  MO1148  M L26 CRAIT HOME, P. A.  KELLY CRECORY (NK  MO1148  M L26 CRAIT HOME, P. A.  KELLY CRECORY (NK  MO1148  M L26 CRAIT HOME, P. A.  KELLY CRECORY (NK  MO1148  M L26 CRAIT HOME, P. A.  KELLY CRECORY (NK  MO1148  M L26 CRAIT HOME, P. A.  KELLY CRECORY (NK  MO1148  M L26 CRAIT HOME, P. A.  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Place of Date Place Of Date Place Of Date Place Place Of Date Place Place Of Date Place Place Place Of Date Place Place Of Date Place Pl	HAROLD LYNCH  19a. Informant's Name-Pleationship (Type, Print)  19b. Mailing Address (Street and Number of Lynch Number, City or Town, State PLORENCE BROWN  20a. Method of Deposition  303. Memoral for State  4   Donastion > 5   Other (Specify)  21. Signatury Either at Service Lynnsy  4   Donastion > 5   Other (Specify)  22. Name and Address of Reality P. A.  4   25 CRAIN HWY SW CLEN Brunning  23. Part I. Enter the diskage to Consplications that caused the death. Do not enter the mode of drying, such as cardiac or respiratory arrest, immediate druss (Final disease or cardiac or respiratory arrest, immediate druss (Final disease or cardiac or respiratory arrest, any, leading to immediate gause. Enter Underlying in death)  5 Sequentially list conditions. Enter Underlying in death)  23a. Was decedent pregnant in the past 12 months?  9   Unknowth 10   Due to (or as a consequence of):  4   Due to (or as a consequence of):  5   Due to (or as a consequence of):  4   Due to (or as a consequence of):  5   Due to (or as a consequence of):  6   Due to (or as a consequence of):  7   Due to (or as a consequence of):  8   Due to (or as a consequence of):  9   Unknowth 10   Due to (or as a consequence of):  9   Unknowth 10   Due to (or as a consequence of):  10   Very and the original in the past 12 months?  11   Yes   2   No   3    24a   Whs an autopsy proformary death of the proposition of t			

		-	State of Ma State Registrer		artment of Health and Mer	ntal Hygier	21111to 1	21028
	Physicia		1. Decedent's Name (First, Middle, Last)				Day Year	3. Time of Death
1	/Medic	al	GEORGE J. BROCKME	EYER		JLY 2	2001	9:20a <sup>™</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	NE!
	Formered		1036 SUMTER AVE  5. Social Security Number	(In yrs. last birthday)	ROSEDALE If Under 1 Year If Under 24 Hrs. 8.	Date of Birth	BALTIMOE 9. Birtho	ace (State or Foreign
	Funeral Director		213 07 9445 1 M 2 F Usual Residence of Decedent	88 Yrs.	Months Days Hours Min.	(Month, Day, Ye CT 30, 1	915 MARY	ZLAND
	faryland show ed at	'n	10a. State 10b. County MD BALTIMORE	10c. City, Town or Lo	ROSEDALE		10	0d. Inside City Limits 1 ☐ Yes 2 No
	th the N or 28a-1 e notifi	Funeral Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	
	ath w	ral	1036 SUMTER AVENUE	ia 11.0	21237	. Van as Na	U.S.A	
980	be filed within 72 hours after death with the Maryland tal Hyglene. Tall Hyglene and other than "natural", or ferms 23a or 28a-f show event, the Medical Examinar must be notified at	þ	11. Marital Status  12. Was Decedent E Armed Forces?  1		Was Decedent of Hispanic Origin? (Specify if Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2 ☐ Wo Specify:	y Yes or No- an, etc.)	Black, White,	
21215-0036		leted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)		. Kind of Business/Inc	
212	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+	•)	RANE OPERATOR	ST	TEEL MILL	
land	2 should be filed withir and Mental Hygiene. Ia marked other than aumatic event, Ihu M	To Be (	17. Father's Name (First, Middle, Last)  ANDREW J. BROCKMEYER	2	18. Mother's Name (F		den Sumame) ÆREIHN)	
Maryland	5 € Z ±		19a. Informant's Name/Relationship (Type, Print) MARGARET MARQUARDT (SISTER		ng Address (Street and Number or Rural Ri SUMTER AVENUE R	oute Number, Cit OSEDALE ,		
	ges 1 an t of Heal If itam 2 or other	-	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State	1	matory or other place)		. Location - City or To	
Baltimore,	t. Partmen rtant:		' 4 □ Donation 5 □ Other (Specify)  21. Signature of Fundral Service Licensee		LL CEMETERY 7-5-2  Name and Address of FacilityCVACH		BALTIMORE, LE FUNERAL	
Ba	Departing Department of the policy of the po		Show Catas	$\mathcal{I}$ 1	211 CHESACO AVENUE	ROSEI		21237 Approximate
	Pnysician	W 4	disease of condition	ESTICU	LAR CANCER	ispliatory arrest,		Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a	consequence of):	NTIA			
	rted nsit	Examiner	Sequentially list conditions, I any, leading to invisable cause. Enter Underlying Cause (Disease or injury)	consequence of				
8760,	ate be executed hysician and he burial-transit	al Exal	that initiated events resulting in death) Last C. Due to (or as a	consequence of):				
687	ficate t	edical	d					
.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
۵	quires that the signed by ald be detac	by	Part II. Other significant conditions contributing to death bu	t not resulting in the u	ndertying cause given in Part I.		co use contribute to th	e cause of death? ably 4 Unknown
I Records,		Completed				24a. Was an autopsy performed	prior to cor death?	osy findings available inpletion of cause of
Vital	Physiclan: The this certificate har all director, page	Be	25. Was case referred to medical examiner?		26. Place of Death (C	*		
of		1: To	27. Manner of Death 28a. Date of Injury	28b. Time o	and the same of th	<ol> <li>Residence</li> <li>Describe how in</li> </ol>	a 6 □Other (Specify njury occurred	')
ion	Attending F r death. actor: After by the funer	atlor	1 Natural 5 Pending (Month, Day 2 Accident investigation	Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division	al or Attendi s after death. Il Diractor: A id in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju building, etc.	ry - At home, farm, st (Specify)	reet, factory, office 28f.	Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	edical (		examination and/or in	h occurred at the time, date and place, and vestigation, in my opinion, death occurred :			
	To the To the	Me	29b. Signature and title of certifier	Danis M	29c. License number D - 48025	29d.	Date signed (Month, I	Day, Year)
	{ \		30. Name and address of person who completed callse of de	40, - 1.	10023	ANI	R Ar 71M	ORE NO
	Sta	to	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	1229 1103110	70,00	1 1517011	21237
	Registi		JUI 0 6 2004	1. Loon	K)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Annie Curry /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Dital Maryland General If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 5, 1948 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1□M 2√2F 214-54-2960 Maryland 55 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If them 27 is marked other than 'naturet, or items 23a or 28a-f show any injury or other traumatic event. If a Mexical Exercises. 1 Yes 2 No Baltimore Directo Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21217 USA 1908 Druid Hill Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Never Married 2 ☐ Marned Specify: Black 1 ☐ Yes 2 X No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security Clerk 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marita Floried Morris Herman N. Curry 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)
1908 Druid Hill Ave., Baltimore, Md. 21217 19a. Informant's Name/Relationship (Type, Print) Marita I. Curry (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) King Memorial Park 7/8/2004 Woodlawn Md. 21. Signature Funeral Service Licensee 22. Name and Address of Facility  $Tri-State\ F/S/Inc.$ DDC8 St.NW., Wash. D.C.20001 22a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical to (or as a consequence of): Examiner 06010 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending To the recent within 24 hours after death.

To the Funeral Director: All 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only onel and manner stated. 29b. Signatur nd title of certalie 29c. License number 29d. Date signed (Month, Day, Year) 4610

State

Registrar

Baltimore,

P.O. Box 68760

Division of Vital Records,

31. Date filed (Month, Day, Year)

JUL 0 6 2004

30. Name and address of person

32. Registrar's Signature

whip completed cause of death (Item 23a) (Type, Print)

Sparks

East 33rd 5/met # 136

2,8

				State of Maryland / Department of Health and Me  1- State Certificate of Death	ntal Hygie		11000
			2	nogisual	. Date of Death	C004-6	. Time of Death
		*Physicia /Medic		Shirley Elizabeth Cooper		Day Year 30, 2004	0227AM
	>	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	2.0	4c. County of Death	
		#	#	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8		9 Birtholac	e (State or Foreign
	11-	Funeral Director		1 M 2 XF 71 Vs Months Days Hours Min.	(Month, Day, Ye 0/01/193	ear) Country)	
		D		Usual Residence of Decedent	0/01/1/3		
		arylar show	'n	10a. State 10b. County 10c. City, Town or Location			Inside City Limits 1 ☐ Yes 2 ☑ No
		the M	Director	Maryland Baltimore Catonsville  10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country'	
		ours after death with the Maryland rail, or Items 23s or 28s-1 show Examiner must be nuitified at		19 Winters Lane # 204 21228		S.A.	
		death	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specifity 9s, specify Cuban, Mexican, Puerto Ri		14. Race - American Black, White, etc.	
	9	after or ite		1 ☐ Never Married 2 💢 Married 1 ☐ Yes 2 📉 No If Yes, Give 1 ☐ Yes, 2 👿 No. Specify:	oan, otc.)	Specify: Blac	
	00	within 72 hours after des ene. than "natural", or Items the Medical Examinet m	ed by	3 Widowed 4 Divorced Year or Dates:	161	o. Kind of Business/Indus	
	7.	in 72 n "nat	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	100	o. Killa of basillessyfilas	шу
	212	d with	mo	Elementary/Secondary (0-12) College (1-4or 5+)  12 Clothes Presser		Dry Cleaner	S
	ng	12 should be filed within "h and Mental Hygiene." 7 is marked other than "riraumatic event, It a Men	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (i			
	yla	ould to	2	Edward Richard Harris Mary Eliza			
	Maryland 21215-0036	s 1 and 2 should be filed within 72 hr Health and Mental Hygiene. Item 27 Is marked other than "natuu other traumatic event, It a Mazikali		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural I			
	ē,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra once.		Gary Cooper / Husband 19 Winters Lane # 204.  20a. Method of Disposition (Name of Date of Date of Disposition (Name of Date o	Catonsvi	LLe, Mary La c. Location - City or Town,	nd 21228 , State
	ē	ages ant of nt: If ii		1X Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  Garrison Forest Ceme • 07/07/	2004 Owi	ngs Mills.	Marvland
	Baltimore,	mit. Foartme		21. Signature of Funeral Service License 22. Name and Address of Facilit The D			
	ä	Depared Important any ir		4611 Park Hgts. Ave.	, Baltim	ore, Maryla	nd 21215
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,	Int	pproximate terval Between nset and Death
		Pnysician		Immediate Cause (Final disease or condition a. SEPTICEM 14 resulting in death)			INKNOWN
		/Medical Examiner		Due to (or as a consequence of):			
			ē.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
12	,	uted d ansit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			1
1	o,	be executed sician and burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):			
0	8760	cate be ex ohysician the buria	dical	d			
0	9	n certific inding p use as	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy		22d Data of dalisas	
00/	Вох	The law requires that the death certific ste has been signed by the attending page 2 should be detached for use as	by Physician/Me	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delivery Month Da	y Year
0	0	that the death ed by the atte detached for	hysi	1 Yes 2 No 9 Unknown			
0	S, P	uires that signed b d be deta	y Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to the c	
W	ords	v require been sig should b	ted t		1 🗆 Yes	2 No 3 Probabl	y 4 Unknown
	ecord	law ra las be	Completed		24a. Was an autopsy	24b. Were autopsy prior to comple	findings available tion of cause of
>	E E		Con		performed		2No
HIRLEY	of Vital R	ding Physician: The In. After this certificate ha funeral director, page	Be	25. Was case referred to medical examiner?  1   Yes   2   No   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home		a 1704 - 40 - 44	
1/8		Phys	7: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28	d. Describe how i	e 6 ☐Other (Specify) injury occurred	
5	ion	nding F ath. r: After e funera	atior	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
	Division	Il or Attandi after death. Director: A d in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Stree City or Town, S	et and Number or Rural Ro State)	oute Number,
	Ö	spital or At ours after o ieral Direct filled in by					
		To the Hospital or Attanding Physician: within 24 hours after death.  To the Funeral Director: After this certific: completely filled in by the funeral director.	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
		To the Hos within 24 ho To the Fun completely	Med	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, Day	, Year)
		H 3 H 3 /		M full MD D47353		June 30,	2004
		b		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  501 Falck 57 - Mg NLS Most Fall 900 Caton Avenue Bat-	thore, it	raryland 21	229
		Sta Regist	ate rar	31. Date filed (Month, Day, Year)  32 Registrar's Signature			

			State of Marylan		artment of Health and	•	-	<b>9.</b>
			1 - State Registrar	Cei	rtificate of Death	R	eg. No.	21021
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Dea	Day Ye	ar 3. Time of Death
	/Media	al	Leroy Culver  4a. Facility Name (If not institution, give street and number)		4b. City. Town, or Location of De		4 200	/
	Examin	er	Stella Maris Hospice		Baltimore	auı	4c. County of E	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year   If Under 24 H Months Days Hours Mi			Birthplace (State or Foreign Country)
	Director		213-34-4530	Yrs.	Months Days Hours Mi	Mar 6,	1938	Maryland
	/land			y, Town or Lo	cation			10d. Inside City Limits
	a-fsh	ctor	Maryland N/A	Ва	altimore			1 Yes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What	Country?
	s 23a		5000 East Oliver Street		21.205		USA	
<b>,</b>	ritem	Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  1. Was Decedent Ever in U. Armed Forces?  1. □ Yes 2 ☒ No	5. 13. V	Was Decedent of Hispanic Origin? of Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - A Black, V	merican Indian, Vhite, etc.
9	rel', o	ď	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates:	1	I ☐ Yes 2 ☐ No Specify:		Specify:	White
5	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28a-f show the Modical Exa ill etc. ast be rediffed at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give .	dent's Usual Occupation kind of work done during most of w	rorking	16b. Kind of Busine	ess/Industry
21215-0036	within ene. <b>then</b>	Jumo	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired)		Factory	
2	I Hygie other ent, II	Be Co	17. Father's Name (First, Middle, Last)		aborer 18. Mother's N	ame (First, Middle, I		
Maryland	2 should ba and Mental Is marked c	To B	Robert Culver		Ma	rv Baker		
Jan	and and Is m		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number or I		, City or Town, Stat	e, Zip Code)
	1 and 2 Health sem 27		Edna D. Culver / Wife  20a. Method of Disposition 20b. P	5000	East Oliver Str		imore, MD	
nor	Pages nent of I ant: If itu ury or o		The outline of the control of the co		sition (Name of natory or other place)		20c. Location - City	
Baltimore,	permit. Pages Department of Important: If i any injury or o		21. Signature of Euneral Servide Licensee	ro Cre	ematory Inc. 7/5	/04	Baltimo	re MD
ď	F S S S S S S S S S S S S S S S S S S S		Thomas Gregor	Cr	Name and Address of Facility Cemation Society 39 Frederick Roas	Of Maryla	and Inc.	228
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ente	or the mode of dying, such as cardi	ac or respiratory arre	est,	Approximate Interval Between
	Prysician		Immediate Cause (Final disease or condition resulting in death)	FAIW	RE			Onset and Death WE ETE (
	/Medical Examiner		Due to (or as a consequ	ence of):	GLON CANG	FQ		1
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ianea of):	www chiq	-100		Okilovam
	cuted nd ransit	Examiner	triat initiated events c					
760,	ate be executed hysician and the burial-transit	EX	resulting in death) Last Due to (or as a consequ	ence of):				
284	death certificate be executed e attending physician and id for use as the burial-transit	dical	d.					
ROX (	eath certific attending p	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant				23d. Date of	delivery
		icla	in the past 12 months?  1 Yes 2 No 4 Pregnant at time of de		Ectopic pregnancy Other (specify)		Month	Day Year
J.	at the f by th etache	Phys	9 □ Unknown 9□ Unknown					
Š,	es ti gna	by	Part II. Other significant conditions contributing to death but not result	Iting in the un	derlying cause given in Part I.			to the cause of death?
ecords,	raq beer shou	etec				-	s 2 No 3	
ĕ	e fa has je 2	Completed				24a. Was ar autopsy perform	/ prior t	autopsy findings available to completion of cause of ?
VII	iicien: Th certificata rector, pag	O	25. Was case referred to medical		26 Place of De	1 ☐ Yes 2		es 2 No
O	di S	ToB	examiner?  1   Yes 2   No	R/Outpatient	Othor			pecity) hospice
	fter	atlon:	1 ☑Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho		rospics
UIVISION	Attending ir death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be 389 Place of Injury. At hor	no form stee	M 1 Yes 2 No	296 Location (Ct		S S
≧	after after Direct d in by	Certific	4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify,	ne, rarm, stre	ет, тастогу, опісе	City or Town,	eet and Number or State)	Rural Route Number,
	ospita hours unaral ly fille		29a. Certifier 1 Certifying Physician: To the best of my know	/ledge, death	occurred at the time, date and place	e, and due to the ca	use(s) and manner	as stated.
	To the Hospital or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the fu	fedical	(Check only 2 Medical Examiner: On the basis of examinations)  and manner stated.	on and/or inve	estigation, in my opinion, death occ			
	To To	Σ	29b. Signature and title of certifier  ASORUS M		29c. License number		d. Date signed (Mo	* '
	7	1		23a) (Tune E	D4793	1		
			30. Name and a dress of person who completed carse of death (Item	PAUL	PLACE BAUT	MORE,	MD 21	20
	Stat Registra	e	31. Date filed (Month, Day, Year)  JUL 0 6 2004  32. Registrar's Signate		K			

Please Type or Print in Black Indelible Ink	. Ensure All Copies Are Legible
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			1 - For State Registrar	State of Ma	-	epartment of Certificate of		, ,	ene	21032
	Physici /Medi		1. Decedent's Name (First, Middle, Las Virginia	Elizabet	h Cohen			2. Date of Death Month	Day Year 3 20	3. Time of Death
	Examir		4a. Facility Name (If not institution, give	street and number) AL OF (	BALTIMO	RE BALTIA		CITY	4c. County of De	eath .
	Funeral Director			x 7. Age	e (In yrs. last birth	nday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, ) July 9,	9. E 1921	Birthplace (State or Foreign Country) Connecticut
	a-f show	ctor	10a. State 10b. County Md. Baltimor	e	10c. City, Town Pik	or Location esville			,	10d. Inside City Limits 1 Yes 2 No
	23a or 28	ai Dire	10e. Street and Number 7 Springbria	r Lane		10f. Zip Code	208	100	U.S.A.	Country?
036	perinit. Tages 1 and 2 should be liled within 72 hours arier death with fine maryland generated to Health and Mential Hygiene. Important: If time Z7 Is marked othar then "natural", or items 23a or 28a-f show eny injury or other treumatic event, it a Mcdical Examinar must be notified at ODGe.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S.	13. Was Decedent of If Yes, specify Cub		ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify:	
Maryland 21215-0036	within 72 ho jene. r then "natur in a Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5	+)	Decedent's Usual Occu Give kind of work done life. DO NOT use retire HOUSewife	during most of work	ing 16	Homemake	
yland	Mental Hyg Arked othar atic event,	To Be C	17. Father's Name (First, Middle, Last) Phillip	Garceau				e (First, Middle, Ma abeth Nel		
, Mar	and 2 sho ealth and m 27 Is ma		19a. Informant's Name/Relationship (7) Barbara Walker —		7	Mailing Address (Street Springbria	and Number or Rur. ar Lane, I	al Route Number, C Pikesvill	City or Town, State e, Md. 2.	. Zip Code) 1208
Baltimore,	ment of H ant: If ite		20a. Method of Disposition  1  Burial 2  Cremation 3    ' 4  Donation 5  Other (Specify,		cemetery,	Disposition (Name of crematory or other pla Crematory	July 5	5, 2004 B		
21. Signature of Fineral Service Licensee  22. Name and Address of Facility Eckhardt Funeral Chapel, 11605 Reisterstown Rd.,  23a. Part Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory										ls, Md. 2111
E	hysician //Medical ician and previous pricial transit	Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	to consequence of	Preumon ::		or respiratory arrest		Approximate Interval Between Onset and Death
records, P.O. Box 68/60,	by the attending physician tached for use as the buria	Physician/Medical E	23d. Date of do Month	elivery Day Year						
יבו	an signad	by	Part II. Other significant conditions co	stributing to death bu	t not resulting in t	he underlying cause giv	en in Part I.	23e. Did tobac	_	to the cause of death?  Probably 4 Donknown
								autopsy performe	d? prior to death?	
The state of the s										ecify)
	27. Managor Death 1 Natural 2   Accident 3   Suicide 4   Homicide 4   Homicide 2   Accident 3   Suicide 4   Homicide 4   Homicide 5   Pending investigation 6   Could not be determined 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Injury - At home, farm, street, factory, office 2   See. Place of Inju									lural Route Number,
H ede	within 24 hours after To the Funerel Dire completely filled in b	Medical	one)	nicien: To the best of ner: On the basis of and manner stat	examination and/	death occurred at the tire investigation, in my o	pinion, death occurre	ed at the time, date	and place, and du	e to the cause(s)
Ę	D S S K	Y	29b. Signature and title of certifier	Brigare	mD			29d.	Date signed (Mon	th, Day, Year)
	0		30. Name and address of person who compared to the solution of	- BRYAN	IT N	rpe, Print)	VA1 HOS	PITAL	OF BA	ALTIMORE
	Sta Registra	_	IIII N 6 2004	32 Registra	H A	arte				

			1 - For State Registrer	State of Maryland / Dep		•	ne
	Physic	ian	1. Decedent's Name (First, Middle, Last		un	2. Date of Death	3. Time of Death
	/Medi	cal	Michael  4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		2004 6:00 PM
	Exami	ner	3542 Grier Nurser		Street		Harford
	Funeral Director		5. Social Security Number 6. Se			8. Date of Birth (Month, Day, Yea June 28,	9. Birthplace (State or Foreign Country)
	yland		10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	8a-f st	Funeral Director	Maryland Harford	Stree	t		1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number 3542 Grier Nurser	y Poad	10f. Zip Code 21154		Citizen of What Country?
	ns 23	ierai	11. Marital Status				14. Race - American Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If Item 271s marked othar than "natural", or Items 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Å Year or Dates:	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto 1   Yes 2 □ No Specify:  Mexican	Rican, etc.)	Black, White, etc.  Specify:  White
5-0	"natu	etec	15. Decedent's Edu (Specify only highest grad	le completed) 16a. Dece (Give	dent's Usual Occupation a kind of work done during most of work DO NOT use retired)	king 16b.	Kind of Business/Industry
121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-40r 5+)	dent		none
d 2	e filed with Il Hygiene. othar tha	BeC	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid	
ylar	2 should be and Mental Is marked o	To E	Michael Cha	rles Cain	Elsa Yvo	onne Piment	cel
Maryland	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (7)		ng Address (Street and Number or Rus		
	Health Health tem 27 I		Michael C. Cain (: 20a. Method of Disposition		Grier Nursery Road states of the matery of other place)		Maryland 21154  Location - City or Town, State
OE.	Pages nent of P ant: If Its arry or of		1 Burial 2 □ Cremation 3 □ F  '4 □ Donation 5 □ Other (Specify)	terrioval itom State	y Mem. Gdns. July		Cimonium, Maryland
Baltimore,	permit. Page Department of Important: If any Injury or once.	Dulaney Valley, P.A n, MD 21093					
			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	Approximate Interval Between			
	Pnysician	- 10	Immediate Cause (Final disease or condition	Acute Lym	houtic Levkem	la	Onset and Death Four Feen Month
	/Medical Examiner	П	resulting in death)	Due to (or as a consequence of):			
	STICE.	e.	if any leading to immediate	b. Due to (or as a consequence of):			
P	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	с.			
,092	ite be executed lysician and ne burial-transit		resulting in death) Last	Due to (or as a consequence of):			
687	A × 6	dicai					
. Box	at the death certifica by the attending ph tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
<u>Ч</u>	that the			ntributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
rds,	n sign	d by				1 🗆 Yes	2 k No 3 Probably 4 Unknown
Record	The law requires that the cate has been signed by the page 2 should be detache	Completed				24a. Was an autopsy performed? 1 □ Yes 2 ☑ N	24b. Were autopsy findings available prior to completion of cause of death?
		BeC	25. Was case referred to medical examiner?		26. Place of Deat	1  Yes 2  N h Check onlone	o 1 Yes 2 No
of V	Physician: this certific ral director,	P.	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier		me 5 Residence	
	ling After une	Certification:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time o Injury	f 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how inj	ury occurred
Division	al or Attanding after death. I Diractor: After d in by the fune	fical	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, str		28f. Location (Street a	and Number or Rural Route Number.
5		Serti	4 Homicide	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Town, Sta	te)
	To the Hospital of within 24 hours at To the Funaral D completely filled in	edicai	29a. Certifier (Check only one) 1 ► Certifying Physical Certifying Physical Exemi	sician: To the best of my knowledge, death ner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause( red at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	withi To t	Σ	29b. Signature and title of certifier		29c. License number		ate signed (Month, Day, Year)
•			July State Of	NO	041444	Ju	ly 2, 2004
	5		Kenneth Cohen,	empleted cause of death (Item 23a) (Type, MO CM5C-800	Print) 600 North Wolfe	theer ba	throve maryland 21187
	Sta Registi		31. Date filed (Month, Day, Year)  JUL 0 6 2004	32. Registrar's Signature	Soule ?		

MAN			For		State of M	arylan			Health and N	/lental Hy	⁄giene		
		_]	= State Registrar				Ce	rtificate of	Death	2. Date of De	Reg. No	004	21034
Р	hysiciar			e (First, Middle, Last)								2004 <sup>Year</sup>	1955 P M
	/Medica	1	Richar	f not institution, give :	rato			4b. City. Town. o	or Location of Death			County of Death	1333 1
	xamine			.1 Street			5	Baltin				,	
Fu	ineral	!	5. Social Security N			ge (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth	9. Birthp	place (State or Foreign
	ector		218-42-	9142	M 2□F	60	) Yrs.	Months Days	Tiodis iviii.	6-7-			imore, MD
and	*	-	Usual Residence of 10a. State	10b. County		10c. City	y, Town or Lo	ocation					Od. Inside City Limits
Maryl	d sho	5	MD	n/a		]	Balti	more					1 XYes 2 ☐ No
the .	7.28a	2	10e. Street and Nur	mber				10f. Zip Code			10g. Citize	en of What Cour	ntry?
th with	232.0	2	960 F€	ell Stree	et Apt.	615		212	31		USA		
<b>5-0036</b> 72 hours after death with the Maryland	If itam 27 is marked other than "natural", or items 25s or 28s-f show or other traumstic event, the Madical Examiner must be nutlituded or other traumstic event, the Madical Examiner must be nutlituded.	y ruiler	11. Marital Status  1 Never Marri 3 Widowed	ied 2□ Married	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	?		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 XNo	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: who	etc.
-00	eat E	completed by	-	15. Decedent's Edu	cation		16a. Dece	dent's Usual Occur	pation		16b. Kin	d of Business/In	
:1215 within 7: ene.	Madi N	-	(Speci	ondary (0-12)	e completed) College (1-4or	5+)			during most of work d)	ang	М	0 M 7.	
nd 2121 e filed within al Hygiene.	t the	5 -		2th			C	ar Sale			M		
yland buld be fil Mental H	even	0		(First, Middle, Last)  L Joseph	Cerato				18. Mother's Nam				
Aarylan 2 should be 1 and Mental	narke natic	2		ame/Relationship (Ty		hae	19h Maili	na Address (Street	t and Number or Rui				Code)
Ma nd 2 s lith an	27 ls . trau			J. Wend					. Apt. 6				
re, Ma is 1 and 2 of Health a	other		20a. Method of Disj	position		20b. P	Place of Dispo	osition (Name of matory or other pla		Date		ation - City or To	
MCF Pages nent of	nt: If			Cremation 3 □P 5 □ Other (Specify)		E	eenmo	* .		/2004	Bal	timore	, MD
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene.	Important: If itam 2 any injury or other <u>once.</u>			uneral Service Licens		ē		2. Name and Addre	JC				Jr. FH 4D 21224
/Me	sician edical miner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due) If (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											Approximate Interval Between Onset and Death
68760, ficate be executed	physician and s the burial-transit	edical Examine	if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	S	Due to (or as Due to (or as d.				vv				-
. Box (		rnysician/me	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2[ 9 ☐ Unknown	! months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	death 3	□Ectopic pregnanc □ Other (specify) _	у		23	3d. Date of delive Month	ery Day Year
Records, P.O	bed bed	ò	Part II. Other signi	ficant conditions co.	ntributing to death t	but not res	ulting in the u	inderlying cause gr	ven in Part I.		tobacco us		he cause of death?
	ate has	пананио								Yes	opsy ormed? 2 \( \text{No} \)	prior to cor death?	psy findings available mpletion of cause of 2 No
of Vita Physician:	recto	۵	25. Was case refer examiner?  1 X Yes 2	1	Hospital:	ant 2 M	ER/Outpatie	nt 3 DOA Ot	26. Place of Dear			☐ <b>X</b> ther (Specifi	At scene
17 -		ation: 10	27. Manner of Deat  1 Natural 2 Accident		28a. Date of Inju		28b. Time o Injury	f 28c. Inju Wo		28d. Describe			y) He boare
the S	al Diractor: ed in by the	Certification	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In building, e	iury - At ho tc. (Specif	ome, farm, st	reet, factory, office			(Street and wn, State)	Number or Rura	al Route Number,
To the Hospital within 24 hours a	ha Funar bletely fill	edicai	29a. Certifier (Check only one)	1□ Certifying Phy 2⊠ Medical Exami		of examina							
To the within 2	com	Ξ	29b. Signature and	title of certifier					se number			signed (Month,	
	2			Korte	Wy)			0.C.	M.E.		July	y 04, 20	)04
v	3		30. Name of addi	RON LIXT	empleted cause of		11		treet, Ba	Ltimore	, Mary	yland 21	1201
	State Registra		31. Date filed (Mon	nth, Day, Year)	32. Regist	rar's Signa	ature 20						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. Nø. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 June 28, **Physician** 10:35 AM Mary M. Davis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Havre de Grace Harford Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Aug 31, 1 Birthplace (State or Foreign Country) 7. Age (in yrs. last birthday) 5. Social Security Number Funeral Days 1 ☐ M 2 🗓 F Yrs. 66 1937 Maryland 217-60-4332 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County "netural", or Items 23a or 28e-f show oficel Evaniner must be notified at 1 ☐ Yes 2∑ No Aberdeen MD Harford Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21001 USA 1010 Carsins Run Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry treumatic event, the Medical College (1-4or 5+) Elementary/Secondary (0-12) administrative assistant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth eny jiny or other treumatic event 2008. 1986104 William A. Kral Grace Virginia Preston ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jack Davis/spouse 1010 Carsins Run Road Aberdeen, ND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 X Donation 5 ☐ Other (Specify) 21. Signatur of Filneral Service Licensee 22. Name and Address of Facility State Anatomy Board Baltimore, MD 2120 Director 655 W. Baltimore Street Baltimore, MD 21201

Zia. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 days sepsis syndrome Physician /Medical Due to (or as a consequence of): 2 days Examiner pheumonia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 No 3 Probably 4 Unknown Non Huagekins Lymphoma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an COPD autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No certificate 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1√Inpatient 2 ER/Outpatient 3 DOA Certification: To

H800 311945

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within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral

1 ☐ Yes 2 Z No

5 Pending

investigation

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death 1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Street #400 Aberdeen mo 21001

29b. Signature and title of certifier peashent

29c. License number 020048050 29d. Date signed (Month, Day, Year) 04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shuklq, MD 15 South Parker Prashant

State Registrar

32. Registraris Signature 31. Date filed (Month, Day, Year)

JUL 0 6 2004 >

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2. KATHERINE CHESTER DeWITT 2004 July 7:00 PM<sup>M</sup> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Pickersgill Retirement Community Baltimore County

9. Birthplace (State or Foreign Country) TOWSON
If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days **Funeral** Hours Min. 1 ☐ M 2 🛱 F Director 90 Mar 6, 1914 Maryland 578-18-7740 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a. State or 28a-f ahow Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Itema 23s or 28s-1 ahow ury or other traumatic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 ☑ No Maryland | Baltimore County Towson 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 615 Chestnut Avenue 21204 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Social Worker Education 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ٥ Chester Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7407 Knollwood Road, Towson, Maryland 21256 of Disposition (Name of Date 20c. Location - City or Town, State <u>Kathy DeWitt Moran (Daughter)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Lorraine Park Cemetery 7/7/2004 Faltimore, Maryland 21. Signal e of Foretal Succession Passes

Martin D. Lawson Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stage **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): the attending physician P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year jo in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 No 1 Yes 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check on one Be Hospital: 1 | Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 5 Pending Vatural 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A 2 Accident investigation in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of carrifier 29c. License number 25200 un 30. Name and address of person who completed cause \*\* eath (Item 23a) (Type, Print) Anthony Riley, M.D., 6701 North Charles St., Towson, Maryland 21204 32 Bogistian's Signature State Registrar

		1 - State Amend Items Registrar  1. Decedent's Name (First, Middle, Las.		-					7	Date of De		JU4	3. Time of Death
ysici: /ledic		Ward Denton Davi	.S						-	July	Day	2004	6:30 b
amin		4a Facility Name (If not institution, give	street and number	)		4b. City,	Town, or	Location o	f Death		4c. Cou	nty of Deat	h
		tranklin Janare		tal		K	0500	dale			Da	Him	
eral		5. Social Security Number 6. Se	ex 7.A M∑M 2□F	ge (in yrs. la	st birthday) Yrs.	If Under Months	1 Year Days	Hours	Min.	. Date of Bir (Month, Da	ay, Year)		hplace (State or Fore
ctor		Usual Residence of Decedent		41	113.				ĮA.	ug 22,	1962	Mar	ryland
12		10a. State 10b. County		10c. City	Town or Lo	cation							10d. Inside City Lim
3	ğ	Maryland Bal	timore			Fc	sex						1 □ Yes 2 🛣
or other traumatic event, the Medical Examinar must be notified at	Director	10e. Street and Number	CIMOLE			10f. Zip					10g. Citizen	of What Co	L
3		1929 Old Eastern	Avenue,	Apt. ]	В		2	21221				U.S.A	
	Funerai	11. Marital Status	12. Was Deceden	Ever in U.S		Vas Dece			gin? (Spec	fy Yes or No		Race - Ame	rican Indian,
	Ē	1 X Never Married 2 ☐ Married	Armed Forces 1 X Yes 2 If Yes, Give				_	n, мехісап Specify:	, Puerto Hi	can, etc.)		Black, White	e, etc. White
	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			1 1 1 1 1 1 1	ZZU NO	эреспу:			Spe	ecity:	wiite
ĺ	Completed	15. Decedent's Ed (Specify only highest grad			16a. Deced	kind of wo	rk done a	turina mosi	of working	,	16b. Kind of	f Business/	Industry
	İdr	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT u			,				
ŀ							Facto	ory Wo				Bak	ery
	Be	17. Father's Name (First, Middle, Last)									, Maiden Sum		
	은	John E. Davis, S									Anderso		
		19a. Informant's Name/Relationship (7				-					er, City or To		
		John E. Davis, S. 20a. Method of Disposition	r. (Fathe					ern A	venue Da		, Mary		
once.		1X Burial 2 Cremation 3	Removal from State	CO	ace of Dispo	natory or o	other place	·			20c. Locatio	•	
		`4 □ Donation 5 □ Other (Specify	1	Hol.									Maryland
once		21. Signature of Puneral Service Licen:	(50)	()									Home, P.A
a		Le man L	<i>).</i> ()	Mede								Maryl	and 21221
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	plications that cause one cause on each	d the death. line.	. Do not ente	er the mod	de of dying	g, such as	cardiac or	respiratory a	arrest,		Approximate Interval Between
n		Immediate Cause (Final disease or condition	a Sepsis										Onset and Death
l r		resulting in death)	Due to (or a	s a consequ	ence of):								
		Sequentially list conditions,	b. Pheuw										
4	ine	if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequ	ence of):								
	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. CESPIVO	s a consou	Gila	٤							
			Cl 4	s a consequ	erice oi).								
	dicai		Tarana	with	CUCIS	_			_			-	
	Physician/Me	IF FEMALE:	220 Hugo outcom		·								
	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth	2 Fetal	death 3	Ectopic p						Date of del Month	ivery Day Year
	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	at time or de	atn 5L	Other (sp	респу)						,
	P	Part II Other significant conditions or	ontributing to death	but not resul	Iting in the ur	nderlying o	cause dive	en in Part I		23e. Did	tobacco use c	entribute to	the cause of death?
	1 by	Part II. Other significant conditions co	USE	_ C	HF (	Jacki	C ON	10			Yes 2 No		obably 4 Dunkno
	etec	T.	31		11	1:1-	CON	161		-		<u>-</u>	
	ģ	tricuspia valve	replacew	ient,	TEpo	+1+1	50			24a. Was	psy	prior to o	topsy findings availa completion of cause of
	-									1 Yes	ormed? 2 No	death?	2 No
	Completed	06 11/	Hospital:				0.1		of Death (	Check only	one)		
	Be	25. Was case referred to medical examiner?			R/Outpatien		-	4 LI Nu			idence 6 🗆 0		city)
	To Be	examiner? 1 ☐ Yes 2 ☑ No	¹ 1 d Inpat		28b. Time of	1	28c. Injury Work			d. Describe	how injury occ	curred	
	To Be	examiner?	1 ⊴Inpat 28a. Date of Inj (Month, D	ury ay Year)	Injury		1 🗆 '	Yes 2 🔲	No				
	To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	1 ☑ Inpat 28a. Date of Inj (Month, D	ay Year)		М						imher or Di	ral Route Number,
	To Be	examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ay Year)	me, farm, str		y, office		28		Street and Nu wn, State)	illibol of No	
	Certification: To Be	examiner?  1 Yes 2 No  27. Manngr of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be  4 Homicide	28a. Date of Inj (Month, D	ay Year) njury - At hor atc. (Specify)	me, farm, str	eet, factor				City or To	wп, State)		
	ai Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier (Check only 2 Medical Exam	28a. Date of In (Month, D) 28a. Place of Ir building, e	ay Year)  njury - At horetc. (Specify,	me, farm, stro	eet, factor	at the tim	ne, date an	d place, an	City or To	wn, State)	manner as	stated.
	edical Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  1 Yes 2 No	28a. Date of Inj (Month, D	njury - At hor etc. (Specify, t of my know of examinati	me, farm, stro	eet, factor	at the tim	oinion, dea	d place, an	City or To	wn, State) cause(s) and date and place	manner as ce, and due	to the cause(s)
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\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	edical Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one)  29b. Signature and title of certifier	28a. Date of Ini (Month, D) 28e. Place of Iri building, e	njury - At horate. (Specify, t of my know of examinati tated.	me, farm, stro ) vledge, death ion and/or inv	eet, factor	at the time, in my op	number	d place, an	City or To	ecause(s) and date and place 29d. Date sig 7/2	manner as ce, and due	to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 5:15 Lou Edwards 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Franklin Square Hospital Baltimore Rosedale
If Under 1 Year | If Under 24 Hrs. Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours Yrs. Director North Carolina 243-52-4878 Sept.30,1935 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Department of Health and Mentai Hygiene.
Important: It item 27 is marked other then "natural", or Items 23s or 28s-f show important: It item 27 is marked other than "natural be notified at once.

The property or other traumatic event, the Medical Examinat must be notified at once. 1 ☐ Yes 2 X No Director Maryland Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Be Completed by Funeral 612 Norris Lane 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed with and Mental Hygiene. 12th. Grade Day Care Mother Nursery 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ů Malcolm Duncan Margaret Regina Gattion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore Kenneth Edwards/Husband 612 Norris Lane MD21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State ō 1 4 ☐ Donation 5 ☐ Other (Specify) 7/7/2004 Gardens of Faith Cem. Baltimore MD 21. Signature of Funeral Pepvice License 22. Name and Address of Facility
Miller-Dippel Funeral Home, Inc. 6415 Belair Road Baltimore 21206 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or so shock, or heart failure. Let only applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ischemic 2 days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA s after death.

I Director: After this of in by the funeral d 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours aft To the Funeral Di completely filled in 1 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Kes

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

9000 Franklin

32. Registrar's Signature

Square Drive Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** BURNETTE LAMONT EDWARDS JUNE SR. 28, 2004 11:04P. /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner N/A JOHNS HOPKINS HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1(XM 2□ F Months Yrs 46 Director 212-70-1502 MARYLAND Usual Residence of Decedent iled within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits itams 23e or 28a-f show rist : sist be notified at 1 XYes 2 □ No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 GLENWOOD AVENUE 21212 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò 1 ☐ Yes XXNo Specify Specify: traumatic event, the Mudical Exer-BLACK 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION 11th grade LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nd Mental h and 2 should be PAUL EDWARDS SR. MAUDIE MADDEN 2 and ! 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maudie Edwards/Mother other t 6615 Windsor Mill Rd., Baltimore, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Depertment important: if 4 ☐ Donation 5 ☐ Other (Specify) injury GARRISON FOREST 07-08-04 OWINGS MILLS, MARYLAND 21. Signature of Funeral Service Licens william C Brown Community Funeral Home P.A. 1206 W NORTH AVENUE 23 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of). Examiner The law requires that the death certificete be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physiclan Physician/Medical IF FEMALE 980 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo Month Year 4☐ Pregnant at time of death 5 Other (specify) the detached δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 deauir 1 X Yes 1 Yes 2 🗆 No 2 🗆 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 XYes ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Cay 28c. Injury at Work? 28d. Describe how injury occurred
Decared Shot 27. Manner of Death 28b. Time of Certification: After or Attending Found 21 1 Natural 5 Pending after death. 128/04 1 ☐ Yes 2 XNo investigation 2 Accident 6 Could not be 3 🗌 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specity) cation (Street and Number or Rural Route by or Town, State) 624 WCC filled in by 4 Homicide Alge Ane Baltimore City IMI street 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) Within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a O.C.M.E. JUNE 29,2004

State

Registrar

30. Name and address of person who complete

2004

31. Date filed (Month, Day, Year)

JUL

111 Penn Street, Baltimore, Maryland 21201

se of death (Item 23a) (Type, Print)

3 Registrar's Signative

				State of Ma								_	C.	
		•	1 - For State Registrar	oldic of ivid	ii y tarra	•	tificate			110 1110		. No. 2 0 0	1.	2101.0
			Decedent's Name (First, Middle, Last)							1	2. Date of Death		-3	3. Time of Death
	hysici		Charles M.	Easter							July 3,		ear	11:30p M
	/Medic Examin	_	4a. Facility Name (If not institution, give st	reet and number)			4b. City, 7	Town, or	Location of	Death		4c. County of	Death	
			Long View Nursing	g Home				Mano	cheste	_		Carro	011	
	ineral		5. Social Security Number 6. Sex	7. Age	(In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day, Y	ear)	. Birthplai	ce (State or Foreign yland
Dii	rector		215=12=3663 1X			TIS.					Feb. 3,	1921	Mar	Arand
rland	MO M	1	10a. State 10b. County		10c. City,	Town or Lo	cation	-					10c	d. Inside City Limits
Man	181	tor	Mass. Barnstable	•		Marst	ons M	ille	3					1X Yes 2 □ No
th the	or 28	lrec	10e. Street and Number				10f. Zip				100	. Citizen of Wh	at Country	y?
th wi	23a	Funeral Director	31 Prince Ave.					026				U.S.	Α.	
ar dea	er m	nue	32	. Was Decedent E Amed Forces?		. 13. V	Vas Deced Yes, spec	ent of His rfy Cubar	spanic Orig n, Mexican,	in? (Spec Puerto R	ify Yes or No- ican, etc.)	14. Race - Black,	American White, etc	
OOOO	i, or	by F	1 Never Married 2 Married : 3 Widowed 4 Divorced	1 M Yes 2 □ N If Yes, Give Year or Dates:	° WW I	т   1	☐ Yes 2	K No	Specify:			Specify:	Whi	.te
P Por	stura cal E	edit	15. Decedent's Educa	ıtion		16a. Deced	ient's Usua	Occupa	ation		16	b. Kind of Busi	ness/Indu	stry
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A wit	F 3	Completed	12	4	,		Reta	il S	alesm	an		Newsp	aper	s
VIZING Suid be file Mental Hy	d oth	Be	17. Father's Name (First, Middle, Last) Charles B. Ea	etan				į			First, Middle, Ma			
V iou	varke	မှ								-	ueline M			
ITE, MALYIANG Z.I.Z.I.S-UUSO is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.	7 is n traun		19a. Informant's Name/Relationship (Type Doris V. Easter -								Route Number, C			
Hear a	em 2 ther		20a. Method of Disposition	. wile	20b. Pla	ce of Disportery, cren	Sition (Nam	of	or Pr	ince	Ave. M	c. Location - Ci	Mil tv or Tow	ls, Mass.
age of the	nt: If if		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	Metr	netery, cren o Cres	natory or ot nator	her place ⊽ J	e) ulv 5	.2004	+	Baltimo	re.	Md
Dallimore, permit. Pages 1 an Department of Heal	ortant: If injury or		21. Signature of Funeral Service Licensee	)										
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30			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused cause on each lin	the death.								A	Approximate nterval Between
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/6U, e be executed	n and iai-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	conseque	ence of):								
/60,	been signed by the attending physicien and should be detached for use as the burial-transit	cal	d.											
OX DB	as th	Medi	IS SELVIN S					1175-054						
ath cer	tendir or use	an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of 1 Live birth			Ectopic pre	gnancy				23d. Date of	,	
D. BO	the at hed fo	Physician/Med	1 Yes 2 No	4☐ Pregnant at 9☐ Unknown	time of dea	ath 5□	Other (spe	ecify)				Mont	U	ay Year
٠ أَوِّ ا	ed by detac		Part II. Other significant conditions cont	ributing to death bu	ıt not result	ting in the ur	nderlying ca	use give	en in Part I.		23e. Did toba	cco use contrib	ute to the	cause of death?
ords, P.O	sign d be	d by		•		•	, , ,				1 ☐ Yes			bly 4 □Unknown
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The law	age 2	omp									autopsy	d? prid	or to comp ath?	pletion of cause of
	After this certificate has be funeral director, page 2 s	Se C	25. Was case referred to medical						26. Place	of Death	1 Yes 2 (Check only one)	PNO IL	Yes 2	
Of VITA Physician:	nis ce I direc	To B	examiner?	spital: 1 🔲 Inpatie	nt 2□E	R/Outpatien	t 3 🗆 DO	A Othe	er: 4 <del>⊒Nu</del> r	sing Hom	e 5 Residenc	e 6 □Other	(Specify)	
o Light	After ti unera	ino	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 2	28b. Time of Injury		Bc. Injury Work			d. Describe how	injury occurred		
VISION Attending	the t	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	n. Athen	no form at-	M		Yes 2 □ N		3f. Location (Stre	ne and Alumbas	or Oum I I	Courte Manhouse
UIVISION  i or Attending  after death.	Direct J in by	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)	ne, iann, sm	eet, ractory	, office		20	City or Town,		or Murair	toute Number,
DIVISIO  To the Hospital or Attendi within 24 hours after death.	To the Funeral Director: completely filled in by the	calC	29a. Certifier 1 Certifying Physi	cian: To the best o	of my know	ledge, death	occurred a	at the tim	ie, date and	d place, ar	nd due to the cau	se(s) and mann	er as stat	ed.
he Ho	he Fu	ed	(Check only 2 Medical Examinations)	er: On the basis of and manner sta	examination ted.	on and/or inv	estigation,	in my op	oinion, deatl	h occurred	d at the time, date	and place, and	1 due to th	ne cause(s)
To t	Tot	Σ	29b. Signature and title of certifier				290	License	number		29d	. Date signed (	Month, Da	ty, Year)
	1		, Ida					1	231	62		115	104	
	12		30. Name and addr s of person who con		eath (Item :	23a) (Type,	1	Marian III	- Q1		tetero	=. )	1.	11001
	Sta	ite.	31. Date filed (Month, Day, Year)	3# Registra	r's Signatu		1 Ma	noser	. 4.,	-5	( Tanan K 2)	C & V		10 14
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State of Manyland Department of Fleath a state of Manyland Department of Fleath a state of Manyland Department of Fleath as the state of Manyland Department of Fleath a state of Manyland Department of Fleath as the state of Manyland Department of F Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** KON 004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 1 Year If Under 24 Hrs.

Months Days House BA BALTIMORE REHABILITATION EXTENDED CARE 5. Social Security Number 238-98-493 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**₽**M 2□F 47 Director Cavoling Duth Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f ehow the Medical Examinet must be notified at BALTO **Funeral Director** 1 Yes 2 No Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34 212 13 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Nes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry othar than Elementary/Secondary (0-12) College (1-4or 5+) Musician 12 it of Health and Mental Hyg If Item 27 is marked othal or other traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden. Be 2 Geneva Jevona ٩ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mura MD FRANKIE Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 □ Cremation 3 Removal from State permit, Page Department o Important: If any injury or parrison forest VACEM \* 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility 1701 Moullans Duce Switton C. BARO MOZIZIT 23a. Part1. Enter the disease, or complications that chused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) ACQUIRED Onset and Death **Physician** (MMMN) HEAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached fo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 🕱 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 2 X No 1 🗌 Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 ☐ Yes 2 🙀 No 1 X Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attanding 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital or within 24 hours at To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH

State Registrar 31. Date filed (Month, Day, Year)

JUL 0 6 2004

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $J_{uly}^{\text{Month}}$ **Physician** 2004 23:56 STEVEN FRONAPFEL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland-Shock Trauma Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1**火**M 2□ F 522-90-1039 Yrs DENVER, CO 4/8/1957 Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show ral, or items 23a or 28a-f show Exemple rough by notified at Director 1 ☐ Yes 2(X) No ANNE ARUNDEL SEVERN the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1409 HARVEY AVENUE 21144 USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 √2 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or item tother traumatic event, ITEM 2010118. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ XVo Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 OFFICE MANAGER US AIR FORCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HAROLD J. FRONAPFEL BONITA M. SCHUMAN ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEAN FRONAPFEL - WIFE 1409 HARVEY AVENUE, SEVERN, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 20c. Location - City or Town, State ō = 5 1 Burial 2XXXremation 3 Removal from State permit. Page Department of Important: If any injury of \* 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 7/7/2004 BALTIMORE, MD 22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 #M0T148 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician · MULTIPLE THURLES WITH COMPLIED TION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Phyaician: The law requires that the death certificate be executed that initiated events use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Yes 2□ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA <sup>2</sup> Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 ☐ No this funeral Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No 6-30-04 BICYCLIST Somme death. 11:33 PM s after death in by the t 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} \) RODOWNY 175ATDORSEY RUN within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 04, 2004 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 MANYAMON KORELL Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

			1 - State Registrar	State of Ma		/ Depa		lealth and	•	vaiene		21043
	Dhorisi		1. Decedent's Name (First, Middle, Las	it)					2. Date of D	eath		3. Time of Death
	Physicia /Medic		Martha	Jane Foar	d				July	2, 200	)4	4:07 р м
	Examin		4a. Facility Name (If not institution, give 2912 Park Ave.	street and number)			4b. City, Town, of Manches	r Location of Dea ster	th	4c. Cour	nty of Death Carro	11
	Funeral Director		Late to Joje	ex 7. Age □ M 2√2 F	e (In yrs. las 82	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ay, Year)	9. Birthr Cour Mar	place (State or Foreign ntry) yland
	pur M		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation					0d. Inside City Limits
	e Maryla Ba-f sho	Director	Md. Carroll			Manch	ester			<del>,</del>		1 AYes 2 □ No
	th with the 23a or 2 ast be no		10e. Street and Number 2912 Park	Ave.			10f. Zip Code 21.	102		10g. Citizen o	U.S.A	-
0030	be filed within 72 hours after death with the Maryland hat Hygiene id other than "natural", or flems 23a or 28a-f show event, it e Madical Examiner must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates:			Vas Decedent of F f Yes, specify Cub □ Yes 2☐XNo	dispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)		ace - Americ lack, White, city: Whi	etc.
0-C12	ithin 72 ho ne. han "natur e Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College, (1-4or 5		(Give life. I		during most of wo d)	rking	16b. Kind of	Business/In	·
V	lled w tygien her ti	S	12 17. Father's Name (First, Middle, Last)	4			Housewif	18. Mother's Na	/Cinch hairdell			I.
yland		To Be	Robert J.						e Cummir		ате)	
Mary	s 1 and 2 should f Health and Men item 27 la marka other traumatic	-	19a. Informant's Name/Relationship (Dr. Wilbur H. For		and			and Number or R		-		Code)
Θ	s 1 and f Health item 27 other tr		20a. Method of Disposition				sition (Name of natory or other pla		Date	20c. Locatio		own, State
Baitimore,	permit. Pages I Department of H Important: If ite any injury or ot once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	()		Luth	eran Cem	etery Ju	Ly 5, 20	04 Mano	heste	r, Md.
ga	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licer	randf		22	Name and Address Eckhardt 3296 Cha	Funeral	Chapel,	P.A.	<sub>1d</sub> 21	102
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final			Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
)	/Medical Examiner		disease or condition resulting in death)	a. Classification of the control of	a conseque	nce of):	REGET!	TIVE	5774	TE		YEARS
	be tis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseque	PLE ence of):	CEREBI	PAL VI	45eul17	R Acci	DENTI	/\
/60,	te be executed ysician and le burial-transit	cai Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):						
Q	tificat ng phy as th											
C. BOX	es that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal d	leath 3	Ectopic pregnanc Other (specify)	у			Date of delive Month	ery Day Year
J	ss that gned by se deta	by Ph	Part II. Other significant conditions of	ontributing to death b	ut not result	ing in the u	nderlying cause gr	ven in Part I.	23e. Did	tobacco use co	ontribute to th	ne cause of death?
0.0	s peen s		Asp. a	67T10 N	PNE	اهرمان	VITIS			Yes 2. KNo		ably 4 Unknown
Vital Records	The lar ate has page 2	Completed							per	s an 24t opsy formed? 205 No	prior to co death? 1 Yes	psy findings available mpletion of cause of
<u> </u>	lclan certifi ector	Be	25. Was case referred to medical examiner?	Hospital:			CH		ath (Check only			
O	ng Phy fter this ineral d	on; To	1 ☐ Yes 2 No  27. Manner of Death 1 ☑ Autural 5 ☐ Pending	28a. Date of Inju (Month, Da	nt 2□El ry y Year) 2	R/Outpatien 28b. Time of pjury		ner: 4 Nursing lary at rk?		how injury occ		y)
DIVISION	tend leath tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	Α	ury - At hom	ne, farm, str	M 1 =	Yes 2□No		(Street and Nui	mber or Rura	d Route Number,
ā	spital o		29a. Certifier 1 Certifying Ph	vsician: To the best	of my knowl	ledge, death	occurred at the ti	me, date and plac	e, and due to the	a cause(s) and	manner as s	ated.
	To the Hospital or At within 24 hours after of To the Funeral Dirac completely filled in by	Medicai	one)	niner: On the basis of and manner sta	i examinatio	on and/or in	vestigation, in my	opinion, death occ	urred at the time	, date and place	e, and due to	the cause(s)
	5 iž 5 iš		29b. Signature and title of certifler	26						29d. Date sign		∪ay, rear)
	(3)		30. Name and address of person who	completed cause of	eath /ltom (	1//	Prior D	01663 7 EAST		(13	164	
	\						1.1111) 44	OSTMIN	MAIA	20.0	21	157
	Sta	ite	31. Date filed (Month, Day, Year)  JUL 0.6 200	2. Registra	ar's Signatu	гө		USI CHII	1100	100	. ~1.	3
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Mary Margaret Fischer July 2004 1:59p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 603 S. Ann Street APt. 513 Baltimore n/a If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Min. Days Months Hours 1 ☐ M 2 ☑ F 72 10-23-31 Director 215-28-2783 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Itan 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic evant, the Medical Examinal must he approximate the process. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD n/a Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 513 603 S. Ann Street Apt. 21231 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eastpoint Nursing College (1-4or 5+) Elementary/Secondary (0-12) Housekeeping 6th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Raymond Ausmus Mary Margaret Long 2 19a. Informant's Name/Relationship (Type, Print) sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miss Rita D. Stieghanhaw 14 Dovetail Lane Essex, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 7/6/2004 Baltimore, MD Greenmount \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. FH 21. Signature of Funeral Service Licensee Maria 263 S. Conkling St., Baltimore, MD 21224 Lannero 23a. Part1. Ther the disease, or camplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Palmogar **Physician** Obstructive ( hronic 20 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: filled in by the funeral director. Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred after death. Director: After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide To the Hospital o within 24 hours aft To the Funeral Di Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and file of certifier D003389 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VISSING MD 3509 Eastern 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 0 6 2004 Registrar DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Month **Physician** 10:55 AM Shel Den 2004 /Medical 4b City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner SAINT AGNES BALTIMORE HEALTHCARE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Year) 218-70-5677 Days 1 M 2□F 6,21,1960 Director mariland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at 1XYes 2□No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Belmont USA 21216 "naturel", or items 23e filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. KB Land Scaping Elementary/Secondary (0-12) College (1-4or 5+) and Scapel 12th aith and Mental Hygie 27 is marked other r treumetic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be file ment of Health and Mental Hient: If item 27 is marked ott oone Constance yles ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse 3207 Belmont Are. Balto, and. 21216 Gray-Surviving abin other 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department o Importent: ff any injury or once. ö memorial Park July2, 2004 Randaelstown King 22. Name and Address of Facility 3405 W. Free 21. Stone ure of Funeral Service Licensee duces Sonice parto and 2122 elsee Nancy m. Wallace reneral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS cerebrosanal and lung weeks Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequential v list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physiclan/Medical Examiner burial-transit Due to (or as a consequence of) the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ ves 2 □ No 24a. Was an autopsy performed? 2 ☐ No Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 30 No 1 🗌 Yes Certification: To 4 Nursing Home 5 Residence 6 Other (Specify) 28 Date Injury (Month, Day Year) 27, Marher of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and the of certified June 29, 2004

State

DHMH 17 Rev 1/2001

Registrar

JUL 0 6 2004

AGNE5

31. Date filed (Month, Day, Year)

TH CARE 900 CATON AVE BALTIMORE, MO21229
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #20b PER FH G834 8/16/04 Jefertificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Year **Physician** 41 14 4c. County of Death oh an /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Brimfield If Under 24 Hrs. 8. Dat Hours Min. 3 (Mo urc/e arro If Under 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign Country) **Funeral** 1**€**M 2□ F 6413 Months Days 5 Yrs. Director Pages 1 and 2 should be filed within 72 hours efter death with the Menyland nent of Health and Mentel Hygiene. Int! If Item 27 is marked other than "natural", or Items 23s or 28s-f ahow 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 16 Yes 2 □ No Funeral Director 10e. Street end Number 10g. Citizen of What Country? 21061 8063 ranch Was Decedent Ever in U.S. Armed Forces? 1 股子s 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1□Yes 25No Specify. Specify: Black Completed by 3 ☐ Widowed 4 ♥ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion
(Give kind of work done during most of working life, DO NOT use retired)

| Continue of the 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 2 Devator 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number ,a 8063 LUL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) injury 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Years Examiner Due to (or as a consequence of) Medical Certification: To Be Completed by Physician/Medical Examiner Hospital or Attending Physician: The law raquiras that the death certificate be assecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? ension TL Yes 2 NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 3□ DOA this 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attenuing within 24 hours efter deeth.
To the Funeral Director: After a contract of the funeral bird in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29c. License number 29b. Signature end title of certifier 29d. Date signed (Month, Day, Yeer) 00051924 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Herbert P. Henderson MA Mancheste 2973 31. Date filed (Month, Day, Year) 32. Registrer's Signature State JUL 0 6 2004 Registrar

ORIGINAL

**DHMH 16 Rev 6/95** 

			State State Registrar	of Maryland / Depa	artment of Health and Martificate of Death	Mental Hygie	•	2101.7
	Physici	an	1. Decedent's Name (First, Middle, Last)  Judith Gardne			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and not the street		4b. City, Town, or Location of Death Baltimore	June &	4c. County of Dea	7
	Funeral Director		5. Social Security Number  212-42-3144  Usual Residence of Decedent	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Bir 641	rthplace (State or Foreign ountry) MD
	nyland how		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show rount be notified at	Director	MD NA	Baltimo			011	XXYes 2 No
	3a or		902 Honaker Ct.		10f. Zip Code 21225	109	Citizen of What Co	•
	r deatl	Funeral		cedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whi	erican Indian,
2-003p	illed within 72 hours after death with the Marylan Hygiene. ther then "neturel", or items 23a or 28a-f show int, it a Marical Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced Year or	2 No live Dates:	1 ☐ Yes 2 🌠 No Specity:		Specify:	Black
7	nin 72   n "net	plete	15. Decedent's Education (Specify only highest grade completed	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king 16	b. Kind of Business	s/Industry
7	ed withir ygiene. ver than t, tre M	Completed		(1-4or 5+)	lerical	S	ocial Se	ecurity Adm
yland	d all all all all all all all all all al	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma		
	s 1 and 2 should be f Health and Mental item 27 is marked other treumatic ev	<sup>L</sup>	Calvin Gardner  19a. Informant's Name/Relationship (Type, Print)	19b. Maili	Ng Address (Street and Number or Rui	a Panni al Route Number, C		Zip Code)
е, ма	r 27 블로		Timothy Brooks-Husba		Honaker Court,			21225
50	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial ②CCremation 3 ☐ Removal from	1 State	matory or other place)		c. Location - City or	
Бацітог	permit. Pages Department of Importent: If it any injury or o		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	2	rematory Inc.	20.04	Baltimon	re, Md
ñ	Depring Bany		Mannon de	) Ma	arch F/H West 300 Wabash Ave,	Baltim	ore Md	21215
	Physician /Medical Examiner			each line.	er the mode of dying, such as cardiac			Approximate Interval Between Onset and Death
/pg,	ate be executed hysician and the burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	o (or as a consequence of):				
.O. BOX 68	the death certific y the attending p iched for use as	Physician/Medi	in the past 12 months?	nant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	olivery Day Year
ords, r	es ign	leted by P	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.		/	o the cause of death? robably 4 □Unknown
паі месо	The law ate has b page 2 sl	Complet				24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of
>	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)  Hospital: 15	Inpatient 2 ER/Outpatier	Othor	h (Check only one)	- 500	
on or	Jing I. After fune	h		e of Injury nth, Day Year)  28b. Time o Injury	IL 3 DOX 4 INUISING HE	ome 5 Residence 28d. Describe how		ecify)
UIVISION		Certification;	3 Suicide 6 Could not be 28e. Place	e of Injury - At home, farm, stiding, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S		ural Route Number,
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the 2 Medical Examiner: On the and ma	ne best of my knowledge, deat basis of examination and/or in nner stated:	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
	Tot Tot	Σ	29b. Signature at 17th or certifier M.D.		29c. License number P / 7782	3 J	Date signed (Mont	th, Day, Year) 1 2004
	9		30. Name and address of person who completed ca S.M. Favasat, M.D., 30	use of death (Item 23a) (Type,	Print)  Print  Print  Ballimore	e,MD,	21225	
	Sta Registi		31. Date filed (Month, Day, Year) 32.	Registrar's Signature	parte			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY 2, **Physician** 2004 HAMMER 1:00 A HAROLD WILLIAM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE RUXTON PIKESVILLE NURSING HOME PIKESVILLE 8. Date of Birth MAY 24, 1925 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthpiece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**∑**M 2□F Min Months Days Hours 79 077-20-0539 N.Y. Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f ahow Examiner must be nutified at 1 ☐ Yes 2 No Director BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33 STONEHENGE CIRCLE #6 21208 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must once. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SYNAGOGUE ADMINISTRATION RELIGIOUS INSTITUTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HAMMER HAMMER ISIDORE YETTA ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 STONEHENGE CIRCLE #6 - PIKESVILLE, MD 21208 SHIRLEY HAMMER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/5/2004 ARLINGTON CHIZUK AMUNO \* 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and physicien are the burial-t Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760 Physician/Medical as attending IF FEMALE: USB 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 4 Dunknown 3 Probably 1 TYes 2 No Completed peed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has page certificate 2 No 1 Yes 2 No 1 Yes or Attending Physician: Be ( 25. Was case reterred to medical 26. Place of Death (Check only one examiner? Other: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) of person who completed cause of death (Item 23a) (Type, Print) Strept Reiss BOBMO 25 32. Registrar's Signature 31. Date filed (M State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 0840 N **Physician** HALLE 2004 EDWARD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** der 1 Year If Under 24 Hrs. Hopkins N/A Johns 8. Date of Birth Month, Pay, Year) MAR. 14, 1922 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1 M 2 □ F 82 MD 198-14-0593 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show the Medical Examinar must be notified at 1 X Yes 2 □ No BALTIMORE Directo MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ 21210 U.S.A. 910 POPLAR HILL ROAD items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 to Yes 2 □ No If Yes, Give Year or Dates: NAVY 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 🙀 No Specify: WHITE þ 3 Widowed 4 Divorced NAVY Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. other than " College (1-4or 5+) Elementary/Secondary (0-12) JOHNS HOPKINS HOSPITAL SENIOR VICE PRESIDENT traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be .. Pages 1 and 2 should be fill then of Health and Mental H tant: If item 27 is marked ott jury or other traumatic even RACHEL NATHAN MILTON HALLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 POPLAR HILL ROAD - BALTIMORE, MD 21210 ELLEN HALLE / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removat from State permit. Page Department o Important: if any Injury or once. BALTIMORE HEBREW CEM. 7/4/2004 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Boay Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. tmmediate Cause (Final HYPOXIA Pnysician DAY disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** DAYS ASPIRATION PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) DAYS Physician: The law requires that the death certificate be executed burial-transit ACCIDENT CEREBRAL VASCULAR that initiated events resulting in death) Last Due to (or as a consequence of). Box 68760, nding physician Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Tyes 2 🗙 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 **X**No 1 Yes 1 🗌 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of 27. Manner of Death 28c. Injury at Work? After the Hospital or Attending 1 Natural 5 Pending after death.

Director: Af
d in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2,2004 JULY RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MARYLAND 21287 20 WOLFE STREET DAVID LIM NORTH 600 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUL 06 m Registrar

ORIGINAL

Michael Ronald Hoeck 04-4279 MAN . For

### umpend item#23a,27,28a-f,PER ME,G833,7/8/04eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland State of Maryland		irtment of H tificate of L			0.0	0.1.0
			Registrar  1. Decedent's Name (First, Middle, Last)	<u> </u>	lilicate Of L	Jeani	Reg. I	Not.	3. Time of Death
	Physici /Medio		Michael Ronald Hoeck				June 30,	2004 Year	2007 P M
	Examir		4a. Facility Name (If not institution, give street and number)		_	Location of Death		4c. County of Dea	
			Saint Josephs Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. las	t hirthday)	TOWSON	If Under 24 Hrs.	8. Date of Birth	Baltimo	Te thplace (State or Foreign
	Funeral Director		220-06-8678 128M 2DF 21	Yrs.	Months Days	Hours Min.	Month, Day, Yes	1982	Maryland
)	pur *		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limits
	Manyli f sho	tor		dwin					1 □ Yes 2 XNo
	or 28a	Director	10e. Street and Number	CUULII	10f. Zip Code		10g.	Citizen of What C	ountry?
	ath wi	rai	13513 Devonfield Drive		21013			nited Sta	
36	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow disal Examinar out be nutified at	by Funerai	11. Marital Status  1	l l	Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2X No	spanic Origin? (Spanic Origin), Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	hin 72 hou e. an *natura Wedical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa kind of work done d	ition Jurina most of work	na 16b	. Kind of Business	/Industry
121	c •_ 5	mple	Elementary/Secondary (0·12) College (1-4or 5+)	life. L	00 NOT use retired, Student	)		<b>-</b> 4	
d 2	illed Hygi ther nt.	Be Co	17. Father's Name (First, Middle, Last)		o tudent	18. Mother's Name	(First, Middle, Maid	Educat:	rou
/lan		To B	Stephen Philip Hoeck			Deborah	Ann Woodwa	ard	
Maryland	2 4 5 5		19a. Informant's Name/Relationship (Type, Print)				l Route Number, Cit		Zip Code)
di.	1 and Health tem 27 other tr	1	Stephen P. Hoeck/father  20a. Method of Disposition 20b. Place	e of Dispo	3 Devonfi sition (Name of	1		. MD 2' Location - City or	Town, State
OE.	Pages nent of nt: If I		I A Burial 2 Ucremation 3 Linemoval from State	-	natory or other place Memorial	· 1	5/2004	Fallsto	n, Maryland
Baltimore,	permit. Pages 1 Department of H Importent: If Ite any injury or ot once.		21. Signature of Planeral Service Consee  S. Coster		Name and Addres	· Ru	ck Towson son, Mary		Home, Inc.
			23a. Part1. Enter the disease, occomplications that caused the death. shock, or heart failure. List only one cause on each line.						Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Narcotic Intox		n				Onset and Death
-	Examiner		Due to (or as a consequent	nce of):					
L	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nce of):					
	and and I-trans	Examine	Cause (Disease or injury that initiated events c	nce of):	· · · · · · · · · · · · · · · · · · ·				
68760,	icate be executed physician and s the burial-transit	aiE	300 to (c) as a somewass	100 01).					
		<b>f</b> edical	0.						
Вох	law requires that the death certifics as been signed by the attending pt 2 should be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de	ath 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
0	that the dealed by the and detached for	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of deal 9 ☐ Unknown 9 ☐ Unknown	th 5 🗆	Other (specify)		<del></del>	(410)1111	Suy Tour
Д.	es that igned by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulti	ng in the ur	nderlying cause give	n in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ecords,	v require been sig should b						1 ☐ Yes	2 □ No 3 □ P	robably 4 Dunknown
Seco	a law r has be e 2 sh	ompleted					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
al R	lcien: The certificate ha	e Col	25. Was case referred to medical				performed		2 □ No
f Vital	ys dir	lo Be	examiner?	VOutpatien	Othe	-	n (Check only one) The 5 Residence	6 □Other (Spe	cifv)
n of		on: 1	27. Manner of Death 28a. Date of Injury 2	Bb. Time of Injury	28c. Injury Work		28d. Describe how in		,,
Division	Attending or death. ector: After by the fune	cati	3 Suicide 6 Could not be			′es 2. No	unknown  28f. Location (Street	and Number or P	um I Pouto Alumbor
	7 3 7 6	Certification;	4 Homicide determined building, etc. (Specily)	o, rattii, otit	set, factory, office		City or Town, Sta	ate)	Parkville,MD
	To the Hospitel conthin 24 hours after To the Funeral D completely filled in	edicai (	29a. Certifier (Check only one)  1□ Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tim restigation, in my op	e, date and place, inion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as and place, and due	s stated. to the cause(s)
	To ti To ti comp	Ž	29b. Signature and title of certifier		29c. License			Date signed (Mont	• •
			Larol Hallan ma	0-1/5		.M.E.	Ju	ly 01, 2	UU4
			30. Name and address of person who completed cause of death (Item 2 $113$			Baltimor	e, Maryla	nd 21201	
	Sta Registr	100	31. Date filed (Month, Day, Year)  32. Registrar's Signatur	y .	bouls				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ysicia	an	Decedent's Name (First, Middle, La.	st)						<ol><li>Date of De Month</li></ol>	ath Day	Year	3. Time of Deat	
Medic		JOSHUA	HOLMAN						July :	2004		0515 P	
amin	er	4a. Facility Name (If not institution, giv	e street and numb	er)		4b. City, Town,	or Location	of Death		4c. Coun	ity of Death		
		Harbor Hospital		A // /-	n A. In lands and a cold	Baltim tf Under 1 Yea		or 24 Hrs.	2 Date - ( Die		0.5:4		
eral		5. Social Security Number 6. S 217-11-3981	ex XXM 2□F	Age (In yrs. la:	Yrs.	Months Days			8. Date of Bir (Month, Da		Cou	place (State or For ntry)	
ctor		Usual Residence of Decedent					<u></u>		2/21/19	86	MARY	/LAND	
14		10a. State 10b. County		10c. City,	Town or Lo							10d. Inside City Lin	
fled	ţo	MD ANNE AR	UNDEL		SEV	ERN						1 □ Yes 2√X	
not	Director	10e. Street and Number				10f. Zip Code				10g. Citizen o	f What Cou	ntry?	
27	O E	8109 BEVERLY ROAD				2114	+4			USA			
	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S	. 13. \	Was Decedent of	Hispanic O	rigin? (Spe	cify Yes or No		ace - Ameri		
著書	Ē	1XXNever Married 2 ☐ Married	Armed Force		-	f Yes, specify Cu			Hican, etc.)	1	lack, White,		
E	l by	3 Widowed 4 Divorced	If Yes, Give Year or Date	9S:		1□Yes 2□XX	Specify	γ.		Spec	ify: WHI	I I E	
lical	Completed	15. Decedent's En (Specify only highest gra			16a. Deced	dent's Usual Occi	ipation e during mo	st of workii	na	16b. Kind of	Business/Ir	ndustry	
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• • • • • • • • • • • • • • • • • • • •	Be	17. Father's Name (First, Middle, Last,								Maiden Sum			
natic	<sup>L</sup>	MARK HOLMAN	T 61.		467			ZABETH		ELLIOTT			
reun		19a. Informant's Name/Relationship (		D					<b>.</b>		or Town, State, Zip Code)		
thar		ELIZABETH N. ELLIC 20a. Method of Disposition	II - MUIHE			BEVERLY RO	JAU, SE		ate LAND				
0 10		1 Burial 2 Cremation 3		ate cer	metery, cren	natory or other pi	ace)			20c. Location		omi, state	
jury		`4 □Donation 5 □Other (Special		BA	1	REMATORY		7/7/2		BALTIMO			
any injury or other treumatic event, the Medical Exertified intermed by notified at once.		21. Signature Funeral Service december 22. Name and Address of Facility FINK FUNERAL HOME 426 CRAIN HICHWAY S., GLEN BURNIE, MD 2											
e a											1061	Approximate	
ician		23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure.											
		Immediate Cause (Final disease or condition resulting in death)  DROWNING											
ical iner	resulting in death)  Due to (or as a consequence of):												
11161		Sequentially list conditions, b. Due to (or see a consequence of):											
÷	lne	Due to (or as a consequence of):  cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):											
-tran	кап	that initiated events resulting in death) Last	C. Due to (or	as a conseque	ance of):								
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88 88	Physician/Me	IF FEMALE:	23c. If yes, outco	me of pregnan	cv					224 [	Date of deliv		
for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	h 2 ∏Fetalo nt at time of dea	death 3	Ectopic pregnan Other (specify)	су				Date of deliv Month	Day Year	
ched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknow		a 0 _	3 Other (Spoony)							
detached for use as		Part II. Other significant conditions	contributing to dea	th but not result	ting in the u	nderlying cause o	iven in Parl	til.	23e. Did t	obacco use co	ntribute to t	he cause of death	
ed b	d by								10	Yes 2□No	3 Pro	bably 4 Unkn	
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recto	Be c	25. Was case referred to medical examiner?	Hospital:			C	than		(Check only o				
raid	T.	1 XYes 2 No 27, Manner of Death	28a Date of	Injury 3	R/Outpatien 28b. Time of	IL SU DOA	4 🗆 1			dence 6 C		fy)	
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y the	fica	3 Suicide 6 Could not b										al Boute Number.	
inb	ertification:	4 Homicide determined		ntry BE		eet, factory, office			City or To	MI, State) UF	CHARD	BEACH, L COUNTY	
fillec	0	29a. Certifier 1☐ Certifying Pl	rysician: To the b			n occurred at the	time, date a						
completely filled in by the funeral director,	edical		niner: On the bas and manne	is of examination	on and/or in	vestigation, in my	opinion, de	eath occurre	ed at the time,	date and place	e, and due t	o the cause(s)	
ldmo:	Me	29b. Signature and title of certifier				29c. Lice	ise number	r		29o. Date sign	ned (Month,	Day, Year)	
. 0		> 2 1 1	10x	12	*	o.c.	M.E.			July 2	, 200	4	
		30 Name and address of person who	completed cause	of death (Item:	23a) (Tvna					_			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  2. Reference of person who completed cause of death (Item 23a) (Type, Print)  2. Reference of person who completed cause of death (Item 23a) (Type, Print)  3. Name and address of person who completed cause of death (Item 23a) (Type, Print)  3. Reference of person who completed cause of death (Item 23a) (Type, Print)  3. Reference of person who completed cause of death (Item 23a) (Type, Print)  3. Reference of person who completed cause of death (Item 23a) (Type, Print)  3. Reference of person who completed cause of death (Item 23a) (Type, Print)											

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2004 **Physician** 27, 3:35P M Aloysius John Hennigan June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Lutherville Stella Maris If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 4//1935 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 206-28-6178 69 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene it with the Marylan item 23 or 28 and 1 show other treumstic event, item Model Examination to other treumstic event, item Model Examinations MD 1 ☐ Yes 257tNo Harford Director Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21040 1915 Bayberry Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No White Baltimore, Maryland 21215-0036 Specify: Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postal Clerk US Mail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Francis Hennigan Sr. Margaret Walsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other trei once. 1915 Bayberry Road Edgewood, Maryland 21040 Ruth Hennigan/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Balto./Wash. Crematory 6/29/04 Laurel, Maryland 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility Bradley-Ashton-MatthewsF.H. Inc. M00521 2134 Willow Springs Road Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CIRRHOSIS OF THE LIVER disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 🗌 Yes 2**X** No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence (Specify) 1 Yes 2**X** No 2 ER/Outpatient 3 DOA After this c funeral din Certification; To HOSPICE 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation ours after death. nere! Director: A filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 2Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aff To the Funerel Di 🛣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 dulaney valley rd. TImonium, MD 21093 DR. TARIQ MAHMOOD

DHMH 17 Rev 1/2001

State Registrar

31. Date sled (Month, Day, Year)

ALOYSIUS HENNIGAN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name, (First, Middle, Last) 2. Date of Death 3. Time of Death 15 AM Year **Physician** Jones 3000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Ma thing MO Mai If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 213-52-1 M 2 DF 55 Yrs. 164 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Pres 2 No NIA Be Completed by Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3700 Apt. 509 21215 USA Greenspring Ave. 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 ☐ Widowed 4 ☐ ivorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. markad other than Elementary/Secondary (0-12) College (1-4or 5+) Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill timent of Health and Mental Hitant: If Itam 27 Is marked oth jury or other traumatic evan William Dolores Larrinaton 19a. Informant's Name/Relationship (Type, nt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Farmer Balto. ve. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Gremation 3 ☐ Removal from State Lorraine Park Important: I any injury o once. \* 4 ☐ Donation /5/☐ Other (Specify) 21. Signature of Fineral Signice 22. Name and Address of Facility ton PASS Balto 23a. Park. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracerebro /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Iding physician and Ise as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? HILL 1 Yes 2 No 3 Probably 4 Donknown rension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Mellitus Dishetes 2 No 1 Yes 2 No 1 Yes of Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funaral Director: / completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License numbe: 29b. Signature and title of certifier D. a. sever 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar K. Misner

31. Date filed (Month, Day, Year)

, D.O.

JUL 0 6 2004

DHMH 17 Rev 1/2001

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nou Hospital
32. Registrar's Signature

			State RegistrarAMEND ITEM	State of M	arylan H G83	d / Depa 3 7/09	rtment o 704 JH tificate	f Health of Deat	and M		giene		21054
	Dharist		Decedent's Name (First, Middle, L.							2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic		Margaret	Jonas						July	2, 200		2:52 a <sup>M</sup>
	Examin	er	4a. Fecility Name (If not institution, gi the Woodlands				4b. City, Tow Middle	e Rive	r			imore	
	Funeral Director		181-24-3346	Sex 7. A. 1 □ M 2 🔀 F	ge (In yrs. 83	last birthday) Yrs.	If Under 1 Y Months Da	ear If Und	der 24 Hrs. s Min.	8. Date of Birtl (Month, Day Oct. 16,	1920	9. Birthp Cour Penn	olace (State or Foreign otry) sylvania
	yland now		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	10d. Inside City Limits
	the Marylan 28a-f show	ctor	Maryland Baltimo	ore	Mi	ddle R							1 ☐ Yes 2 🔀 No
	with th	Funeral Director	10e. Street and Number	od Doom 2	<b>0</b> 2		10f. Zip Coo				10g. Citizen of U.S.		ntry?
	eath v	eral	1320 Windlass Roa	12. Was Deceden	t Ever in U	.S. 13. \	Vas Decedent	of Hispanic	Origin? (Sp	ecify Yes or No-		ce - Americ	can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or itams 23a or 28a-f show amy righty or othar traumatic event, the Medical Examination ust be notified at once.	by Fun	1 ☐ Never Married 2 ☐ Married  3X Widowed 4 ☐ Divorced	Armed Forces  1  Yes 2  If Yes, Give Year or Dates:	? <b>M</b> o		f Yes, specify ( I □ Yes 2Ω	Cuban, Mexi	can, Puerto	Rican, etc.)	Bla Specii	ck, White,  fy: W	etc. hite
215-0036	r2 hou	ted	15. Decedent's l	Education		16a. Deced	tent's Usual O	ccupation	nost of work	ina	16b. Kind of E	Business/In	dustry
121	vithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Homem	kind of work di DO NOT use re	etired)			Own Ho	omo	
C	filed withi Hygiene. othar than ent, the M		17. Father's Name (First, Middle, Las	st)		пошеш	aver	18. Mo	ther's Nam	e (First, Middle,			
Maryland	uld be Aental rked c	To Be	Andrew Jonas AM	DREW PERI	O			Ma	ry Ku	ntz			
lar)	2 should and Men la marke raumatic		19a. Informant's Name/Relationship		٦					al Route Numbe			
	1 and Health am 27 thar t		Bobby Crowder (Bi	cotner-in-	20b. F	Place of Dispo	sition (Name o	of	*	Baltimor	20c. Location	•	
nor	ages ant of l it: If its y or o		1 ☐ Burial 2XX Cremation 3  '4 ☐ Donation 5 ☐ Other (Spec		∌		natory or other Cremato		7/3/:	2004		-	aryland
Baltimore,	mit. P partme portan y injur	1	21. Signature 15un ral Sent, Lic		1 100	22	. Name and A	ddress of Fa	cility			•	
ä	Depar Impo any ir		1-2		>	1	407 old	d East	ern A	venue, I	ii Home Essex, I	Marya	Ind 21221
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	/Medical Examiner		resulting in death)	Due to (or a									
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8760,	certificate be executed adding physician and use as the burial-transit	al Ex	resulting in death) Last	Due to (or a	s a consec	quence or);							
Ó	ifficate g phys as the	edicai		O							Part   1		
Box	atter for u	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	al death 3	Ectopic pregn Other (specif					ate of delive onth	ery Day Year
, P.O	res that the de igned by the be detached		Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying caus	e given in Pa	art I.	23e. Did to	obacco use con	tribute to t	he cause of death?
rds	w require been sig should b	led b	NON MSU	lin De	per	nde	W D	ices	ctes	7 1 DY	es 2 No	3 Prot	pably 4 □Unknown
Vital Records,	م ح م	Completed by					me	Lhi	TUS	perfo	an 24b.	Were auto prior to co death? 1 \( \subseteq Yes	opsy findings available impletion of cause of
/ital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	11					ace of Deat	h (Check only o	ne)	ASET	TED
of \		10	1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital: 1 ☐ Inpa		ER/Outpatier			Nursing Ho	ome 5 Resid			ELIVING -
O	ling After Fune	tlon	1 Natural 5 Pending 2 Accident investigat	28a. Date of In (Month, D	ay Yeer)	Injury	м	Injury at Work? 1 Yes 2	□No		,,		
Division of	I or Attandii after death. Diractor: A I in by the fu	Certification:	3 Suicide 6 Could not 4 Homicide determine	289. Place of I	njury - At h etc. <i>(Speci</i>	nome, farm, sti	reet, factory, of	fice		28f. Location (S City or Tox	Street and Num m, State)	ber or Rura	al Route Number,
-	To the Hospital or Attanc within 24 hours after death To the Funaral Director: completely filled in by the	edical C		Physician: To the bes aminer: On the basis and manner:	of examina								
	To the within 2 To the comple	Me	29b. Signature and title of certifier	9		-	29c. Li	icense numb	er 7 0		29d. Date signe	ed (Month,	Day, Year)
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	10		30. Name and address of person when BA YIN OUNG	M.D,	802	2 Bt	Print) 52AU	2 120	A-0	BACT	Time	21	1 md
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	-	strar's Sign	ature	home so	~ /					

State of Manufand / Department of Health and Mental Hygiene

			Certificate of Death		eg. NØ. / /	1. 2	LOCE
		1	Decedent's Name (First, Middle, Last)	2. Date of Dea Month		Year	3. Time of Death
	Physician		ESTELLE JOHNSTON.	June		324	6:30PM.
	/Medica Examine		la Facility Name (ff not institution, give street end number)  4b. City, Town, or Local	ation of Death	4c. County o	f Death	
4	LAUIMINE		MERCY HOSPITAL BALTIMORE		N,	/A	
	Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8	8. Date of Birth (Month, Day	Year)	9. Birthpled	e (State or Foreign
	Director		212-28-5071 1 M 2XX 77 Yrs. Months Days Hours Mill. S	SEPT. 4	, 1926		YLAND
	ю	-	Usual Residence of Decedent			40.	
	show	.	10a. State 10b. County 10c. City, Town or Location			100	I. Inside City Limits  1
	r 28a-f	g 1	MARYLAND N/A BALTIMORE				
	1 th	Director	10e. Street and Number 10f. Zip Code		0g. Citizen of W	hat Country	P
	deeth with the Maryland one 23e or 28e-f show proved Director	<u>a</u>	1807 E NORTH AVENUE 21213		U.S.A		
		Funeral	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispenic Origin? (Specify Cuban, Mexican, Puerto R	rify Yes or No- lican, etc.)	14. Race Black	- American , White, etc	
9	at a a	또	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXNo Specify:		Specify:	BLAC	ĸ
8	within 72 hours efter and "natural", or fre he Medical Examina	ρ O	3∕OWidowed 4 □ Divorced Year or Dates:				
5	72 t	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	g	16b. Kind of Bus	siness/indu	stry
2	ight.	E C	Elementary/Secondary (0-12) College (1-4or 5+)		DOMES	CmT C	
2	Hygle v fither th	ဒီ -	unknown LAUNDRY WORKER  17. Father's Name (First, Middle, Last) 18. Mother's Name (	/First Middle			
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ž	2 should be filed end Mental Hygistem marked other aumatic event,	ို				State Zin C	inde)
Maryland 21215-0036	d 2 should th end Mer 7 la marke traumatic						
	Heeith Heeith Hee 27 I	-	Ernestine McDaniel/Daughter 1807 E. North Ave., Bal	Date	20c. Location - C		
0	ges tof h	- 1	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State			,	
Baltimore,	permit. Peges 1 end Depertment of Heelth Important: If frem 27 any injury or other to once.		4 □ Donation 5 □ Other (Specify) GARRISON FOREST VETERANS 0	7-07-04	OWINGS	MILL	S, MARYLANI
39	Demit Deper Impor		21. Signature of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMI	UNITY E	UNERAL I	HOME :	P.A.
ш	<b>₹</b> □ <b>= 3 3</b>		Markara 1206 W NORTH AVENUE				
			23a/ Part1. Enter the diseese, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory ar	rest,	A Ir	pproximate nterval Between
	Physician						Onset and Death
4	/Medical		Immediate Cause (Final disease or condition a Congustive Heart Failure			i	seare
1	Examiner		resulting in death)  Due to (or es a consequence of):			(	j
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	eath certificate be executed attending physicien end for use as the buriet-transit	edicai Examiner	0.				0
oʻ	en e	ŭ	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):				
68760,	ite be	<u>8</u>	Cause (Disease of Injury that initiated events resulting in death) Last  Due to (or as a consequenca of):				
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Box	th ce sendii r usa	aZ	d				
	Attending Physician: The law requires that the death cert of deeth.  sctor: After this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use	Be Completed by Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did t	obacco use con	tribute to t	he cause of death?
P.0	t tha by th	<u></u>		101	'es 2□ No	3 🗌 Proba	bly 4 Unknown
Š	as tha igned be de	2					
Ď	v requiras been sign should be	8		24a. Was	en autopsy med?	avail	autopsy findings able prior to
ပ္တ	s been 2 shoul	D et				of de	pletion of cause leth?
æ	he law la has age 2:	E		1 🗆 Y	es 2 No	1 🗆 '	Yes 25 No
of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours eftar deeth.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	9	25. Wes case referred to medical 26. Place of Death	(Check only o	ne)		
5	s cert	0	exeminer?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5□Resid	ence 6 Othe	r (Specify)	
0	Phys eral di	2	27. Menyer of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28	8d. Describe h	ow injury occurre	∍d	
0	th. After	읉	1 ☑Natural 5 ☐ Pending (Month, Dely Year) Injury VIOIN 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No				
Division	Atter r dee octor	≌	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office 28e.	8f. Location (S City or Tow	treet and Number	r or Rural I	Route Number,
ă	efta Dira	e	4 ☐ Homicide building, efc. (Specify)	Only of Ton	n, Steley		
	To the Hospital or Attending I within 24 hours effer deeth. To the Funeral Director: Affer completely filled in by the funeral parts of the funeral completely filled in by th	edicai Certification: To	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, er	nd due to the	ause(s) and mar	ner as ste	ted.
	P Ho 24 F Fulletely	융	(Check only one)  2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred and manner stated.	d at the time,	date and place, a	nd due to t	ne cause(s)
	omp state		29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Da	ay, Year)
	F > F 0		Mampell Than Poon, md, FACP D 57088		June ?	20,2	ery.
	1	1	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)			,	
		/	Thow from. 301 ST Paul Plan, # 701, Baltimon	(m)	91505		
	State	0	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registra	.6	1111 2				
D	HMH 16 Rev 6/95		JUL 6 2004 Jenn B. January				
			ORIGINAL				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Mo. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2055 M DOROTHY KERRIGAN 29 2004 LEE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE OF MARYLAND UNIVERSITY

5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Days Hours 1 ☐ M 2 🖸 F Yrs Jan 15, 219-20-5888 78 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2√ No MD Baltimore Baltimore Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4300 Cardwell Avenue #220 21236 USA Funeral Pages 1 and 2 should be filed within 72 hours efter deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: white ģ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) of Health and Mental Hygiene. homemaker own home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lydia Fay Tober Leland Watson Wood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 714 Priestwood Road Churchville, MD 21028 Gary Williams/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Depertment of H Importent: If Ite any injury or ott ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signatur of Euneral Privice Licensee Director Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Physician /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician Completed by Physician/Medical be detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No 2 No Division of Vital 26. Place of Death Check on one Be 25. Was case referred to medical examiner? Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 No funeral 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident the after death 28f. Location (Street and Number or Rural Route Number City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 15846 JUNE 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South BALTIMORE SONIA BLOME GREENE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State me s JUL 0 6 2004 Registra

			For State Registrar	State of	Maryland / [	Departmen <i>Certificat</i>				lental Hy	ygiene Reg. No.	004	21057
			Decedent's Name (First, Middle, I	ast)						2. Date of D	oath		3. Time of Death
	Physici /Medic		John J.	Kent						JULY	2, 2	2004 Year	11:55a <sup>™</sup>
	Examin		4a. Facility Name (If not institution, g					Location of	of Death		4c. (	County of Dea	_
			Beaverbrook Ass				olun		24 Hrs	10.000		Howa	
	Funeral Director		5. Social Security Number 6 065-10-5763 Usual Residence of Decedent	. Sex 7. 1 M M 2 □ F	. Age (In yrs. last bii 86	Yrs. Months	Days	Hours	Min.	8. Date of B NOV 2	7, 19	17 f	irthplace (State or Foreign Indis
	land		10a. State 10b. County		10c. City, Tow	m or Location							10d. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other treumatic event, the Medical Frant art must be notified at	tor	Maryland Ho	ward		Col	umb	ia					1 Tes 2 No
	n the	Director	10e. Street and Number			10f. Zip	Code				10g. Citiz	zen of What C	Country?
	23a c		5802 Wyndham	Circle			21	L044			U;	SA	
	ems	Funeral	11. Marital Status	Armed Force	ent Ever in U.S. es?	13. Was Deced	ent of H	ispanic Ori an, Mexicar	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	10-	<ol> <li>Race - Am Black, Wh</li> </ol>	nerican Indian, nite, etc.
36	s afte	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat		1 ☐ Yes	2 <b>X</b> No	Specify:				Specify: W	hite
9	tural	edt	15. Decedent's	Education		. Decedent's Usua	al Occup	ation			16b. Kin	nd of Busines	s/Industry
21215-0036	nin 72 In "na Media	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	4or 5+)	(Give kind of wo	rk done d se retired	during mos d)	it of work	ting			
212	giene giene er the	E	Liothoritary/55555/idaily (5 72)	5+		Atto	rney	<b>/</b>			Ge	eneral	Practice
p	be file	Be	17. Father's Name (First, Middle, La	st)						e (First, Middle		Sumame)	
yla	Men Men Marke	ို	August Kent		-					Malco1			
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any highry or other freumatic event, the Mean once.	h	19a. Informant's Name/Relationship John J. Kent, Jr			5. Mailing Address 5802 Wynd				al Route Num. Columbi	-		
e,	1 and Healt em 2		20a. Method of Disposition		20b. Place o	of Disposition (Nar	ne of	-		Date			or Town, State
Baltimore,	ages ant of it: If it y or o		1 ☐ Burial 2X Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		tate	ory, crematory or o Cremator			7/3	/04	Re	altimo	ro MD
Ħ	artme orten Injur		21. Signature of Funeral Service Lie	PARSAN CO DO	10					of Mary			re, MD
Ä	Depa Depa Impo any li		▶ TWING	Donald	ancx	299 Fr	eder	nick l	Road	or mary Balti	more	, Inc.	1228
	8 E. I		23a. Part1. Enter the disease, or co shock, or heart failure. List or	iv one cause on ear	used the death. Do	not enter the mod	e of dyin	g, such as	cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Congestiv	e Hout	- Ca	lure					Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	r as a consequence	of):							
	LXAIIIIICI	يا	Sequentially list conditions,	b. Due to /o	r as a consequence	of).							
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	200 10 (0	i as a consequence	017.							
<u> </u>	be executed iician and burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (o	r as a consequence	of):							
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dlcail		d									
9	ntifical ng ph as th	Medi	IE EEMALE.										
Вох	death certific attending pl	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		ome of pregnancy th 2 Petal death	n 3 ⊟Ectopic pr	egnancy	,			2	3d. Date of de	elivery Day Year
0.	w requires that the death been signed by the atte should be detached for	by Physician/Me	1 Tyes 2 No	4□Pregna 9□Unknov	nt at time of death wn	5 ☐ Other (sp	ecify)						,
Δ.	that the	Ph	Part II, Other significant condition	s contributing to dea	ath but not resulting i	in the underlying c	ause giv	en in Part I		23e. Did	tobacco us	se contribute	to the cause of death?
Records,	uires signa Id be	d by	Diabotes	Mellitus	·	, ,	_			1 🗆	]Yes 2□	]No 3∏F	Probably 4 Unknown
cor	w req	lete								24a. Wa	s an	24b. Were a	autopsy findings available
Re	sician: The law certificate has b lirector, page 2 s	Completed								auto per 1 ☐ Yes	opsy formed?	death?	o completion of cause of es 2□No
of Vital	an: T	Be C	25. Was case referred to medical					26. Place	e of Deat	th Check only	-	1010	Annintal
Ţ	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 🗆 In	patient 2 ER/O	utpatient 3 DC	Oth Oth	er: 4 🗆 Nu	ursing Ho	ome 5 Res	sidence 6	Other (Sp.	Pecify) Living
0	ng Ph fter th neral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month	Injury 28b.	Time of 2	8c. Injun	y at k?		28d. Describe	how injury	occurred	134.4416
Sio	eath. or: A	catl	2 Accident investiga 3 Suicide 6 Could no	t be		М		Yes 2	No				
Division	or At ufter d Direct in by	Certification:	4 Homicide determin	289. Place o	of Injury - At home, fag, etc. (Specify)	arm, street, factory	, office				(Street and own, State)		Rural Route Number,
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical Ce	(Check only 2   Medical Ex	Physician: To the backariner. On the back	מו יוטוו וויווו אלש לי כוכ	e, death occurred	at the tir	ne, date ar	nd place,	and due to the	e cause(s) a	and manner a	as stated.
	thin 2 the I	Med	one) 29b. Signature and title of certifier	and manne	er stated.			e number					nth, Day, Year)
	T S I S	F	250. Signature and title or certifier	000 0		200	131	1610			)	1. 1	2004
	0		30. Name and address of person w	no completed cause	of death (Item 23a)	(Type, Print)	10	1413		5.04	J	17 21	200
			Ste en 6	er M	101	014	Ann	000	No	$ \mathcal{E} $	with (	CALA	11) 2/042
	Sta	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature	Asa s	11	1000				1	T

			1- For State of Maryland / Department Certification	ent of Health and ate of Death		ene .2004 21058
	Physicia		1. Decedent's Name (First, Middle, Last)  Walther Kirchner		2. Date of Death Month June 30	Day Year 3. Time of Death 7:35P M
	/Medic Examin		Ab C	City, Town, or Location of De Baltimore	eath	4c. County of Death N/A
	Funeral Director		559-28-3060 1€3 2□F 99 Yrs. Mont	nder 1 Year   If Under 24 H ths Days Hours M	in. (Month, Day, Y	9. Birthplace (State or Foreign Country) Berlin, Germany
	Maryland f show	ior	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland N/A Baltimo			10d. Inside City Limits XX Yes 2 □ No
	with the I 3a or 28a- If be notifi	Direct	10e. Street and Number 830 W. 40th Street	. Zip Code 21211	10g	g. Citizen of What Country?  USA
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28e-f show other traumatic event, the Medical Exertical must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Was Decedent Ever in U.S. Armed Forces?  1 Yes, 3 No If Yes, Give Year or Dates:	ecedent of Hispanic Origin? specify Cuban, Mexican, Pu as XX No Specify:	(Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: white
Maryland 21215-0036	i within 72 hou iene. Iene. I than "natura	ompieted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  8+  Educator	Usual Occupation If work done during most of OT use retired)  r/Historian	working (	Sb. Kind of Business/Industry College Professor
land 2	uld be filed Aental Hyg rked othar tic evant,	To Be C	17. Father's Name (First, Middle, Last)	18. Mother's MAlic	Name (First, Middle, Ma CE	aiden Sumame)
	and 2 should like the sale of		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addi Virginia G. Collie (Friend)  19b. Mailing Addi 8009 St	rauff Road	Towson, Ma	
Baltimore,	Page nent c ant: if ury or		20a. Method of Disposition  XX Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (cemetery, crematory)  Quaker Cemetery	or other place)		oc. Location - City or Town, State Princeton, NJ
Balt	permit. Departr Importe any inji		Burge	e and Address of Facility ee-Henss-Seit Falls Road	Raltimore	MD 21211
	rny sician and /Medical Examiner	dical Examiner	23a. Part 1. Enter the disease or complications that caused the death. Do not enter the shock, or heart failule. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Listass or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	mous or dyling, such as care	uiac or respiratory arres	d. Approximate Interval Between Onset and Death
.O. Box 68760,	death certific e attending p id for use as	Completed by Physician/Medical E		oic pregnancy r (specify)		23d. Date of delivery Month Day Year
rds, P	requires that the een signed by th hould be detache	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying to the significant conditions contributing to death but not resulting in the underlying in the underlying to death but not resulting in the underlying in th	ng cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
Division of Vital Records,	The law rearte has bee page 2 sho	Complete			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 → No
f Vita	ding Physician: The lavh. h. Affer this certificate has funeral director, page 2.	To Be	25. Was case referred to medical examiner?  1   Yes   2   No   Hospital: 1   Inpatient   2   ER/Outpatient   3	26. Place of Other: 4 \(\begin{array}{c}\text{Nursin}\end{array}\)	Death (Check only one) ng Home 5	ce 6 □Other <i>(Specify)</i>
sion o	Attanding PI r death. sctor: After the tuneral	Certification:		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	
Divi	To the Hospital or Attandir within 24 hours after death.  To the Funeral Director: All completely filled in by the fu				City or Town,	
	the Hosp in 24 hou the Fune ipletely fil	ledical		ation, in my opinion, death o	occurred at the time, date	
	5 5 5 5 5	Σ	29b. Signature and vitte of certifier	29c. License number 72 3076		7 - 1 · 07
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	30 Fulls	Rel Ba	H Md 71211
	Sta Regist		15 12 11 6 7/1/1/8 1/20 h a head Add	uls		

		1	For State Registrar	State of Maryl		artment <i>rtificate</i>			and M		giene Reg. No 2	04	21059
	Physicia	an	1. Decedent's Name (First, Middle, Las	Nancy Lee	Kelley					2. Date of Dea Month	Day	Year 2004	3. Time of Death 0922 A M
	/Medic Examin		4a. Facility Name (If not institution, give					Location o			4c. Count	y of Death	
			SINAL HOSPITA  5. Social Security Number 6. So	ti of BAUTIE	700E yrs. last birthday,			1000 E	24 Hrs.	8. Date of Birth		9. Birthi	place (State or Foreign
	Funeral Director		213-30-4215	□M 2XX 70	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day June 7,	, 1934	Cou	yland
	pu *	-	Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or L	ocation						1	10d. Inside City Limits
	Maryla f sho	ō	MD N/A		Baltimo								XX Yes 2 No
	n the	Director	10e. Street and Number			10f. Zip					10g. Citizen of		ntry?
	ath wit	rai D	918 West 37th St		. 110		212		-i-2 (C	afu Vaa aa Na	U.S		can Indian,
36	perritt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Marical Examinar must be notified at an ODE.	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ※ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	in U.S. 13.	Was Deced II Yes, spec		spanic Ori n, Mexican Specify:	gin / (Spe i, Puerto	ecify Yes or No- Rican, etc.)	Speci	ck, White,	
5-0036	r2 hou	ted	15. Decedent's Ec	ucation	/Give	edent's Usua e kind of wor	k done o	<i>lurina</i> mos	t of worki	ing	16b. Kind of E	Business/In	ndustry
31212	d within 7 giene. er than "n	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	lite.	retary	e retired	)				P1umb	oing
Maryland 2121	uld be file Aental Hy rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Charles 0						Edna	e (First, Middle, a Fanwe)	11		
Mary	12 sho h and h 7 Is ma trauma		19a. Informant's Name/Relationship (Meldon Kelley (S							Balto,		ı, State, Zij 211	o Code)
	ages 1 and of Healt it if item 2		20a. Method of Disposition  XXBurial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specification of the control o	Removal from State	ob. Place of Disp ulaney	osition (Nan	ne of	1		Date	20c. Location Timoni		
Baltimore,	perr it. P. Dep rtme Important any injury		21. Signature of Funery Service Licen	4	- 3	Name and Burgee 3631 F	d Addres Her	s of Facilit SS-Se Road	eitz d	Funera Balto, I	1 MD 212	1 <sup>Inc</sup> .	
ls	Pnysician		23a. Part 1. Enter the disease, of com shock, or heart failure. List only Immediate Cause (Final			nter the mod	e ol dyin	g, such as	cardiac (	or respiratory ar			Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a co	nsequence of):								
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8760,	death certificate be executed e attending physician and of for use as the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	nsequence of):			eer v		THE COVE			
Box 68	eath certificat attending phy for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		□Ectopic pr	eonancy					ate of deliv	rery Day Year
P.O. B	ne deat the atte	ysicia	in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknowh	4☐Pregnant at time 9☐Unknown		Other (sp					IV	lonth	Day 16ai
	law requires that the de as been signed by the a 2 should be detached f	þ	Part II. Other significant conditions of	contributing to death but no	ot resulting in the	underlying c	ause giv	en in Part I		23e. Did to	-/		the cause of death?
Vital Records,	0 = 0	Completed				<u> </u>				24a. Was autor perfo		prior to co death?	opsy findings available ompletion of cause of
ita	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?				0.1			h (Check only o			
of	Phys	2	1 Yes 2 No  27. Manner of Death Natural 5 Pending	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpation 28b. Time Injury	of 2	8c. Injur Wor	y at		ome 5 Resident			ify)
Division	t or Attending efter death. Director: After in by the fune	Certification;	2 Accident investigatio 3 □ Suicide 6 □ Could not b 4 □ Homicide determined	e 290 Place of Injuny	At home, larm, s Specify)			-		28f. Location (. City or To		nber or Rui	ral Route Number,
	Hospital 4 hours Funeral iely filled	edical C	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nysician: To the best of m niner: On the basis of exa and manner stated	amination and/or	ath occurred investigation	at the tir	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and n	nanner as , and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	A		290	c. Licens	e number			29d. Date sign	_ `	
	1/			unta MI			RE	5-00	0		July 1	4,200	04-
	<b>b</b>		30. Name and ad ss of person who	completed cause of death		e, Print)	Hosi	MAL	_ 0	F BAU	MORE	-	
	St Regist	ate	31. Date liled (Month, Day, Year)	32. Registrar's		Span	Kge						

KELLEY, NANCY

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** KUSHNER /Medical 4b. Gity, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner KANDALLS TOON NORTHWEST BALTI If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 20 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Year) 1**∑** M 2□ F Months Days Hours Min 220-18-8589 78 Yrs. Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10b. County 10a. State 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f show The Medical Examinational be notified at Md. Baltimore Reisterstown 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 64 Main St. U.S.A. 21136 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Food Market Credit Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Benjamin Kushner Myrtle Lauderbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 Is any injury or othar trau once. Donald Kushner - Brother 113 Glenmoore Ave., Cockeysville, Md. 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory July 5, 2004 Baltimore, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Eckhardt Funeral Chapel, F.A.

11605 Reisterstown Rd., Owings Mills, Md.
Approximate Interval Between Onset and Death 22. Name and Address of Facility
Eckhardt Funeral Chapel, P.A. 21. Signature of Faneral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-transit physician and Due to (or as a consequence of): Box 68760, Physician/Medical the as guipo esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten 3 Ectopic pregnancy in the past 12 months? jo Day 4☐ Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ DEMBNIA 4/ Unknown 1 Yes 2 No 3 Probably leted peeu 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Compl page 2 certificate 1 Yes No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. D te of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28d. Describe how injury occurred 27 Manner of Death 28b Time of 28c. Injury at Work? Certification: Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 o the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTHWESTHOSPITAL CTR - MAHEZHWARI 31. Date filed (Month, Da 32 Registrar's Signature Day, Year) 2004 State KS COLOR Registrar

			1- State of Maryland / Registrer		artment of H		and Me		jiene	04	21061
			Decedent's Name (First, Middle, Last)				2.	Date of Dea	th	V	3. Time of Death
	Physici /Medio		Hamid Khawaja				J	Month June 2	Day 20	Year 004	7:50p M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location o	f Death		4c. Cour	nty of Death	
			Casey House		Rockvil:	le			Mon	tgomer	÷у
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign intry)
Ш	Director		229 <b>-</b> 67 <b>-</b> 1657	Yrs.					919	Indi	
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	wn or Lo	cation						10d. Inside City Limits
	Aaryl f sho	5	Md Montgomery Ger	rman	town						1 ☐ Yes 2 ☑ No
	the 286-	rect	10e. Street and Number		10f. Zip Code			1	l0g. Citizen o	of What Cou	Λ.
	3e or	Ö	11 Indian Grass Court		20874				USA		•
	ter death Items 2:	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.	13.	Was Decedent of H	ispanic Orig	gin? (Specif	y Yes or No-	14. R	lace - Ameri	
9	or Ite	Fur	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 1 □ No		f Yes, specify Cuba		, Puerto Rio	an, etc.)		lack, White,	
03	ral', c	1 by	3 Widowed 4 □ Divorced If Yes, Give The Year or Dates:		I□Yes 2X No	Specify:			Spec	city: whi	te
5	be filed within 72 hours after death with the Maryland tal Hygiene. Identition "natural", or Items 23e or 28e-1 show odther then "natural", or Items 23e or 28e-1 show event, it e Madical Examiliar mast be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	a. Deced (Give	lent's Usual Occup kind of work done OO NOT use retired	ation during most	of working		16b. Kind of	Business/Ir	ndustry
121	within ene. then	шb	Elementary/Secondary (0-12) College (1-4or 5+)	-	oo not use retired inessman	4)			0.000.00		
2			17. Father's Name (First, Middle, Last)	Dus	THESSIIIGH	19 Mothor	r'e Nama /F	First, Middle,	grocer		
anc	be for the formula is even	Be	Bashir Ahmad				saima		Maideri Suini	ame)	
Ž	should be filed nd Mental Hygi marked other umatic event,	To	19a. Informant's Name/Relationship (Type, Print)	h Mailie	g Address (Street				City or Tou	m State 7i	n Codo l
Maryland 21215-0036	S S	113			dian Gras				-		
d)	is 1 and 2 should of Health and Meritem 27 Is marker other traumatic		20a Method of Disposition 20b. Place	of Dispo	sition (Name of	And an incompany	Date	-	20c. Location		
10	ages ant of it: If ii		1 La Buriai 2 Cremation 3 Li Hemovai from State L	_ ~	natory or other place Memorial	. )	-27-0	/1	Sykesv	1110	ма
Baltimore,	permit. Pages 1 Department of H Importent: If ite eny injury or ot once.		21. Signature of Funeral Service Licensee		, Name and Addre						
Ä	Per Per Per Per Per Per Per Per Per Per		Harry Tw. Hour lit	P	.O. Box 1	.95 Sv	kesvi	11e. M	d 2178	MARIE CA	Chaper
			23a. Part1. Enter the disease, or complication, that caused the death. Do shock, or hear failure. List only one cause on each line.								Approximate Interval Between
Ü	Physician		Immediate Cause (Final								Onset and Death
	/Medical		disease or condition resulting in death)  a.     neumonia   Due to (or as a consequence   Due to	e of):							3 wks
н	Examiner		Sequentially list conditions b.								
	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause 1 for the year of the yea	of):							
	ecute and trans	Examin	Cause (Clease or Fijury) that initiated events resulting in death) Last  Due to (or as a consequence								
8760,	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence	9 (31):							
87	cate t	dical	d								
9 ×	eath certific attending p	0 1	IF FEMALE: 23c. If yes, outcome of pregnancy						204.5		
Вох	atten for u	sian	in the past 12 months?		Ectopic pregnancy Other (specify)				l l	Date of deliv Month	Day Year
o.	by the a	Physician/M	1 Yes 2 No 9 Unknown								
<u>α</u>	the ed	by Pł	Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying cause giv	en in Part I.		23e. Did tol	bacco use co	intribute to t	he cause of death?
rds	quires in sign uld be		Coronary Artery Disease					1 □ Ye	es 2X No	3 🗆 Prot	pably 4 □Unknown
Vital Records,	law requir as been si 2 should	Completed	Parkinsons Disease				[	24a. Wasa		. Were auto	ppsy findings available
Re	The la ate ha	E O		_				autops perforr 1 ☐ Yes	iy ned? 2.☑ No	prior to co death? 1  Yes	mpletion of cause of
ital		O	25. Was case referred to medical			26. Place	of Death (C	Check only on	_41	1 1 1 1 1 1 1 1 1	
Į <	d is	To B	examiner?  1  Yes 2 No	utpatien	t 3 DOA Oth	0.0		5 🗆 Reside		nn 6 766 6	, House
n of				Time of Injury	28c. Injun World	y at k?	28d	I. Describe ho	w injury occ	urred 1	respice
Sio	Attending or death. ector: After by the fune	catl	2 Accident investigation		M 1 🗆	Yes 2□N	No				
Division	il or Attend after death Director: ,	Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, to building, etc. (Specify)	arm, str	eet, factory, office		28f.	Location (St City or Town	reet and Nun n, State)	nber or Rura	al Route Number,
	pital ours a srel D		Continue (ST Contitute Observation To the best of making the continue of the c								
	Hos 24 ho Fun Fun	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	nd/or inv	estigation, in my o	ne, date and pinion, death	h occurred	at the time, d	ause(s) and r ate and place	nanner as s and due to	itated. o the cause(s)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Med	29b. Signature and title of certifier		29c. License	e number		2	9d. Date sign	ned (Month,	Day, Year)
	-> P- O		DE P. Zebré	M	Δ DO 94	70			June 26	5 2004	+
•	2		30. Name and address of person who completed cause of death (Item 23a)	(Type,	Print)						
_	0		Eugene P. Libie MD 10400 Connecti			singto	on, Md	208	95		
	Sta	_	31. Date filed (Month, Day, Year)  JUL 0 6 2004  2. Registrar's Signature	,	Sporks						
	Registi	ar	JUL U 0 2004		•						

				State of Maryland	/ Departm		h and Me	ental Hygi	ene		21062	
			Registrar		Certino	ale of Dea		2. Date of Death	g. No.		3. Time of Death	
	ysicia Medic		1. Decedent's Name (First, Middle, Last) Ethe1	M. Kavalesk				Month July	1 <sup>Day</sup>	2004°	22:28 M	
	amin		4a. Facility Name (If not institution, give st	reet and number)	4b.	City, Town, or Locati	on of Death		4c. C	County of Death		
			Carroll Hospital (				inster			Carrol		
	eral ctor		217-09-7321	7. Age (In yrs. las 92	st birthday) If U Yrs. Mor		der 24 Hrs. rs Min.	8. Date of Birth (Month, Day, Jan. 10	Year) , 19	9. Birth Cou	place (State or Foreign ntry) MD	
faryland show	polisi	or	Usual Residence of Decedent  10a. State 10b. County  MD Carrol 1		Town or Location						10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
the N	#	ect	10e. Street and Number		10	. Zip Code		10g. Citizen of What Country?				
with	20	٥	1231 Washington Ro	ad		21157				USA		
portition of the property of the reconstruction of the property of the propert	saminer mus	by Funeral Director		2. Was Decedent Ever in U.S. Armed Forces? 1		ecedent of Hispanic specify Cuban, Mex es 2 XNo Spec		cify Yes or No- Rican, etc.)		4. Race - Ameri Black, White Specify: Whi	, etc.	
n 72 hour	edical E	Completed b	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decedent's (Give kind of life. DO No	Usual Occupation of work done during to OT use retired)	most of working	199	16b. Kin	d of Business/Ir	ndustry	
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Hygi The	nt.		17. Father's Name (First, Middle, Last)				lother's Name	(First, Middle, M				
d be ental	0	To Be	Calvin Sproul				Rosea	nne Swar	n			
shound M	ита	-	19a. Informant's Name/Relationship (Typ	e, Print) (Niece)	19b. Mailing Add	dress (Street and Nu	imber or Rura	Route Number,	City or	Town, State, Zi	p Code)	
alth a	ar tra		Mrs. Mary Ellen Li	velsberger	78 Ceda	r Lane Th	omasvi					
as 1 a of He liter	othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	cen	ice of Disposition metery, crematory	or other place)	1			ation - City or T		
Page nent	o Aur		'4 □Donation 5 □ Other (Specify)	Lak	e View M	lem. Park	7/6/0	4	Syk	esville	e, MD	
permit. Depart	any in		21. Signature of Funeral Service License	Haight	Haig Syke	ht Funera sville, M	acility Home ID 2178	& Chape 4 (410)-	e1, -795	PA (Box -1400	195)	
*			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	eations that case I the death.							Approximate Interval Between	
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ted	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or if Jury) that initiated events	Due to (or as a conseque	ence of):							
obe exected to the control of the co	e burial-tra	cal	resulting in death) Last	Due to (or as a conseque	ence of);							
tificat	as th	ed										
I NECOLUS, P.O. DOX 80/00, The law requires that the death certificate be executed and has been signed by the attending physician and	al director, page 2 should be detached for use as the burial-transit	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1 □ Yes 2 No 9 □ Unknown	ac. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 □Ecto	pic pregnancy ar (specify)			2	3d. Date of delin Month	very Day Year	
ires that t	d be deta	by P	Part II. Other significant conditions con	tributing to death but not result	ting in the underly	ring cause given in P	art I.		acco us		the cause of death?	
law requires	lnous	ete						24a. Was ar	n	24b Were aut	opsy findings available	
The lav	director, page 2	Completed						autops perforn	v .	prior to c death? 1 ☐ Yes	ompletion of cause of	
VILCIII ician: T	ector	Be	25. Was case referred to medical examiner?	ospital:		Other		(Check only on				
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ding	funer	lon	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury at Work? I 1 ☐ Yes		od. Doscribo no	, vi II., G., y	00001100		
UIVISION OI VICAL To the Hospital or Attanding Physician: within 24 hours after death. To the Eurard Director After this certifies	in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, f			28f. Location (St. City or Town		l Number or Ru	ral Route Number,	
Hospita 24 hours	ately fille.	edical C		ician: To the best of my know ter: On the basis of examination and manner stated.								
o the	ldmo	Me	29b. Signature and title of certifier			29c. License num	ber	2	9d. Date	signed (Month	. Day, Year)	
- S -	· /		1 1 A. U.	~ ~ ~		0005193	24		Sala	3,200	4	
	5		30. Name and address of person who co		23a) (Type, Print			/	1	2000		
			Herbert & Henderal		Monches	to RJ M	auche	ta Mi	1 3	-1102		
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Aparks ORIGINAL

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		1	For State Registrar	State of	Maryland		artment of Hertificate of L		nd Mental Hy	giene Reg. Np? () () [	21002
	Physicia		1. Decedent's Name (First, Midd	lle, Last) ETTA			LEVIN		2. Date of Dea		3. Time of Death 1:37 A M
,	/Medic Examin		4a. Facility Name (If not institution		ber)		4b. City, Town, or			4c. County of E	1.07 //
	Examin	eı	HOWARD COUNTY	-			COLU	MBIA			HOWARD
	Funeral Director		5. Social Security Number 089-10-3923	6. Sex 7	. Age (In yrs. I		If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of Birt Month, Da AUG 2	, 1916 <sup>9.</sup>	Birthplace (State or Foreign Country) NY
	and *		Usual Residence of Decedent  10a. State 10b. Count	y	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	Maryl -f sho	ţō	MD	HOWARD		FULT	ON				1 ☐ Yes 2 🎇 No
	n the or 28a e routi	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	
	23a c	ral	11584 SCAGGSV					2075			U.S.A.
	er dez	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	12. Was Deced Armed Ford 1 Tyes 2	es?	S. 13.	Was Decedent of Hi If Yes, specify Cubai	spanic Orig n, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - / Black, V	American Indian, Vhite, etc.
36	urs aft	by F	3 ♥ Widowed 4 □ Divorce	If Yes Give	)		1 ☐ Yes 2 🂢 No	Specify:		Specify:	WHITE
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21215-0036	d within 72 hours after death with the Maryland jene. r than "natural", or Items 23a or 28a-f show It e Madical Examiratingsite modified at	Completed	Elementary/Secondary (0-12)	2 College (1-	4or 5+)	life.	DO NOT use retired, MAKER	)	-	OWN HOME	
N	be filed v ntal Hygie ed other t event, IL		17. Father's Name (First, Middle	, Last)		HONE	THUCK	18. Mother	's Name (First, Middle,		
lan	8 E 2 9	To Be	CHARLES			LANG	ER	BER	RTHA		ERSTER
Maryland	and and Is m		19a. Informant's Name/Relation				,		r or Rural Route Numbe		
	1 and 2 Health Jem 27		DIANE STEINER  20a. Method of Disposition	/ DAUGHTER			WINIERCO psition (Name of	RN LA	NE - COLUMI	20c. Location - Cit	
nor	<b>a</b> o <b>-</b> -		1 Burial 2 Cremation		tate	emetery, cre	CEMETERY		7/3/2004		, NEW YORK
altimore,			* 4 □ Donation 5 □ Other (		WEL				SOL LEVIN		
B	permit. Departi Importi any inj		Total	15							, MD 21208
			23a. Part1. Enter the disease, shock, or heart failure. Li.	or complications that ca st only one cause on ea	used the death ch line.	n. Do not en	ter the mode of dying	g, such as o	cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in dealing	Due to (c	or as a conseq	uency ov:	349.	1-1	TXI		
4		jer	Seque (tally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (c	or as a conseq	uence of):	1101	1	///		Jean
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8760,	ate be executed obly sician and the burial-transit		resulting in death) Last	Due to (d	or as a conseq	uence of):					
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ŏ	death certifica attending ph d for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregna		□Ectopic pregnancy			23d. Date o	
œ.	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?		int at time of d		Other (specify)			Month	Day Year
P.0	that the deed by the detached		9 ☐ Unknown  Part II, Other s q ifica condi	tions contrib	ath but not res	ulting in the u	underlying cause give	en in Part I.	23e. Did t	tobacco use contribu	to the cause of death?
Records,	uires tha signed b	d by	- Ne	note.	- 1				1 🗆	Yes 2 No 3	Probably 4 Unknown
CO	aw requir s been si 2 should	plete	Warken	us 5	Mse	ore			24a. Was	an 24b. Wei	re autopsy findings available r to completion of cause of
I Re		Completed	A	rem.					perfo	ormed? 🦯 📉 dea	th? Yes 2 No
Vital	Physician: r this certific ral director,	Be	25. Was case referred to medic examiner?	Hospital:	The Allerton		otho Otho		of Death (Check only		Death Church
ō	Phya r this ral dir	1: To	1 Yes 2 76	1 U Ir	npatient 2 If Injury h, Day Year)	ER/Outpatie	III SLI DOA		rsing Home 5 Resi 28d. Describe	how injury occurred	similar mins
ion	Attending Part death.  ector: After by the funera	atlor	1 atural 5 Pen	ding (Monti stigation	h, Day Year)	Injury		k? Yes 2□!	No		,,,=,,
Division	r Attenditer death.	Certification:	3 🗆 Suicide 6 🗆 Coul 4 🗆 Homicide dete	d not be mined 28e. Place building	of Injury - At h	ome, farm, st	reet, factory, office		28f. Location ( City or To	Street and Number own, State)	or Rural Route Number,
Q	urs afte		29a. Certifier 1 Certifi	ying Physician: To the	boot of my kno	udadaa daa	th account at the tim		d place, and due to the	course(s) and mann	or as stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medic	al Examiner: On the ba	sis of examina	ition and/or i	ivestigation, in my o	pinion, deat	th occurred at the time,	date and place, and	due to the cause(s)
	To th within To th comp	Me	29s Signature and title of certi	fier /		had	29c. Licens	e number	2120	29d. Date signed (A	Aonth, Day, Year)
•			aujan	Myr	15	10	طرا ر	2) 3	06 22	1/2	134
	6		30 Name and address of person	who completed cause	of death (Iter	m 23a) (Type	HOWA	rd	Co 60	en . Ho	spital
	St	ate	31. Date filed Manth, Day, Ye	INIA SE RI	egistrar's Signa	ature	don di			N. W.	
	Regist	rar	- 002	-	/	/	yours!				

Keith A. Lusby UNK 04-231 04 - 0RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

433	66		For State Registrar	;	State o	f Mar	yland / Dep <i>Ce</i>	artmer ertificat				1ental Hy	giene Reg. No. (	101	21064
			Decedent's Name (First, Middle	e, Last)								2. Date of De	ath	P 400	3. Time of Death
3"	Physicia		Keith Albert	Lusk	V							July 1	2, <sup>Day</sup> 200	)4 Year	0925 P M
	/Medic Examin	-	4a. Facility Name (If not institution			mber)		4b. City	Town, or	Location	of Death			ounty of Dea	
		а	101 Back River	Nec	k Road	É		Ess	sex				Ba	altimo	ore
	Funeral Director		5. Social Security Number 212–76–1089	6. Sex	4 2□F	-	In yrs. last birthdaj 48 Yrs.	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Feb. 14	th 1956	9. Bi	irthplace (State or Foreign Country) ryLand
	and w		Usual Residence of Decedent  10a. State 10b. County			1	0c. City, Town or	ocation							10d. Inside City Limits
	Manyl f sho	0	Maryland Baltin	nore			Essex								1 ☐ Yes XXNo
	the roll	rect	10e. Street and Number					10f. Zij	p Code				10g. Citize	n of What C	Country?
	3a oi	Funeral Director	1635 Frenchs Av	venue	<u>,</u>				21221	1				S.A.	
	death	ner	11. Marital Status		. Was Dece	edent Eve	er in U.S. 13	. Was Dece	dent of H	ispanic Or	igin? (Sp	ecify Yes or No Rican, etc.)	- 14		erican Indian,
21215-0036	within 72 hours after death with the Maryland nne. than "natural", or Itams 23a or 28a-f show Ita Majical Evanirer musi be rollified at	by	1 X Never Married 2 Mar 3 Widowed 4 Divorced		1   Yes If Yes, Giv Year or D	2 🔀 No ve		1 Yes		Specify.		nicari, etc.)		Black, Wh	White
2-0	72 ho natur	Completed	15. Deceder (Specify only highe				16a. Dec	edent's Usu	al Occupa	ation	t of work	ina	16b. Kind	of Busines	s/Industry
21	ithin ne. han "	ηbl	Elementary/Secondary (0-12)	1	College (1	1-4or 5+)		e kind of wo DO NOT u	ise retired	)	,, ,, ,, ,,	9	_	<b>C</b> :	
	filed w Hygien othar ti		10 17. Father's Name (First, Middle,	(act)			Roof	er		10 Math	odo Niem	e (First, Middle		fing	
Maryland	2 should be filed withir and Mental Hygiene. Is marked othar than aumatic avent, the M.	To Be	John Wesley Lu	,								Esplin		,	
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent, the Marical Exercites must be notified at once.		19a. Informant's Name/Relations Mildred Lusby									al Route Numb			
re,	of Hee item otha		20a. Method of Disposition				20b. Place of Disp cemetery, cr	osition (Na	me of	e)		Date	20c. Loca	tion - City o	r Town, State
Ē	Page nent c ant: If		1X Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (S		noval from	State	Meadowri				uly	7,2004	Elkri	dge, 1	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or othar tra		21. Signature of Euperal Service	Censee				22. Name a	nd Addres Bri	s of Facili 1ZdZ1 East	nski ern	Funera	l Hom	e, P.	A. ryland 21221
11	q.		23a. Part1. Enter the disease, o shock or heart failure. List	complica	ations that o	aused th	e death. Do not e							ry Pice.	Approximate Interval Between
	Physician		Immediate Cause (Final disease of condition	only one	Huit					/	1				Onset and Death
	/Medical		resulting in death)	( a.			consequence of):	euro	NUS	ding	asy	hyxia			
ш	Examiner	_	Sequentially list conditions,	b.											
	ed tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ł	Due to	(or as a c	consequence of):								
_	xecut and il-tran	хап	that initiated events resulting in death) Last	c.	Due to	(or as a c	consequence of):				-				
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687	ficate p phys	edical		d.											
.O. Box	that the death certific ted by the attending p detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown	230		oirth 2 [ nant at tim	Fetal death 3	□Ectopic p □ Other (s <sub>i</sub>					230	d. Date of de Month	elivery Day Year
<u>α</u>	requires that the een signed by th nould be detache	y Ph	Part II. Other significant conditi	ons contr	ibuting to de	eath but r	not resulting in the	underlying (	cause give	en in Part	i.	23e. Did t	obacco use	contribute	to the cause of death?
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Ö	~ Q 70	Completed										24a. Was	an 2	24b. Were a	autopsy lindings available
Re	The taw rate has be page 2 sh	om											rmed?	prior to death? 1 2 Ye	completion of cause of
Vital		Bec	25. Was case referred to medica	.1						26. Place	e of Deat	1 X Yes	2 No	1 6	5 2 100
of V	S . D	ToE	examiner? XXYes 2 □ No	Но	spital: 1 🔲 l	Inpatient	2 ER/Outpati	ent 3 Di	OA Othe					Other (Sp.	ecity) At Scene
n o	ding Ph h. After th funeral	ou:	27. Manner of Death 1 □Natural 5 □ Pendi	na	28a. Date	of Injury th, Day Y	ear) 28b. Time	of :	28c. Injury Work	at c?		28d. Describe	how injury o	ccurred	
Sio	eath.	catl		gation	TULY	2,200	4 9:2			Yes 2		Subjec	t was	arra	u I teel
Division	or Atl tter d Diract in by	rtifi	4 Homicide determ		28e. Place buildi	ol Injury ing, etc. (						City or 10	vn, State) "		Rural Route Number,
	pital	I Ce	29a. Certifier 1 ☐ Certifyi	na Dhyeir	cien: To the	hast of r	Wooded					Reak of 10	Balton	ore ca	untry MD
	24 hc 24 hc Fun etely	Medical Certification:		Examine	r: On the b	asis of ex	my knowledge, de: kamination and/or d.	nvestigation	n, i⊓ my op	ne, date ar pinion, dea	nd place, ath occuri	red at the time,	date and pl	d manner a ace, and du	is stated. le to the cause(s)
	To the Hospital or Attanding P within 24 hours efter death. To tha Funaral Diractor: After i completely filled in by the funera	Me	29b. Signature and title of certifie	er				29	c. License	number			29d. Date s	igned (Mon	th, Day, Year)
			Jaska 2	y10	en ho	200	MO		o.c.	M.E.			Julv	3, 20	004
	7		Josha 2 30. Name and address of person	who com	pleted caus	se of Geat	th (Item 23a) (Type	e, Print)						-,	
			Tasha Z Giv	eenb	cr31	4.D.	s Signature		Penn	Stn	eet,	Baltim	ore, M	4aryla	and 21201
	Sta Registi		31. Date liled (Nonth Day, Year 0 6 20	04	Sen	ogistrar's	Signature	Ana.	V. 1						

		State of Maryland / Departmen  1 - State  Certificate		•	e	21065		
		Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Death	o. U 11 4	3. Time of Death		
Physici		MYRTLE ELIZABETH LAYNE		Month Da JULY 3,	ay Yeer 2004	11:60 AM		
/Medic Examin			Town, or Location of Death		c. County of Death	4.00		
Exami			MBRILLS		ANNE ARUNDE	1		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year		place (State or Foreign ntry)		
Director		280-20-0727 1□ M 2√N F 79 Yrs. Months	Days Hours Min.	8/4/1924	WEST	VIRGINIA		
D >		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			1.			
aryla sho	_	MD ANNE ARUNDEL GAMBRILLS			'	0d. Inside City Limits 1 ☐ Yes 2XXNo		
7-88-1	ecto							
with a or 3	늅			10g. C		ntry?		
eath ne 23	Funeral Director			offy You or No		on Indian		
ter d	ä	Armed Forces?    Armed Forces?   If Yes, specifies   If Yes   Specifies   If Yes   Specifies   If Yes   Specifies   If Yes   If Yes   Specifies   If Yes   I	fy Cuban, Mexican, Puerto P	Rican, etc.)				
urs a	ρ	3 XXWidowed 4 □ Divorced If Yes, Give 1 □ Yes 3	No Specify:		Specify: Wh	HITE		
be filed within 72 hours after death with the Maryland tall Hygiene.  ad Hygiene.  ad other than "naturel", or iteme 23a or 28a-f show event, ite Medical Examinar must be notified at	Completed	15. Decedent's Education 16a. Decedent's Usua (Circ kind during Completed)	I Occupation	16b. I	Kind of Business/In	dustry		
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2 should be filed within and Mental Hygiene. Is marked other than aumatic event, it a M	မ							
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ges 1 and 2 should to f Heelth and Mer if item 27 is marke or other traumatic								
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permit. Pages Depertment of Important: If i any injury or once.		Millian Court						
					MD 21061	Approximate		
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Examiner								
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ate be executed hysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events c.						
e be exe sician a burial-i	Ë	resulting in death) Last Due to (or as a consequence of):						
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the de	Physician/M	1 ☐ Yes 2 ☑No 4 ☐ Pregnant at time of death 5 ☐ Other (sp. 9 ☐ Unknown	∍cify)			,		
w requires that the death certifica we require that the death certifica been signed by the attending phy should be detached for use as the		Part II. Other significant conditions contributing to death but not resulting in the underlying co	ause given in Part I.	23e. Did tobacco	use contribute to th	ne cause of death?		
uires sign ld be	d by		,	1 XYes 2	!□No 3□Prob	ably 4 □Unknown		
shou	ete			24a Wee an	24h Wara auta	nev findings available		
he land	Completed	()		autopsy performed?				
vical income recommendation of the law scentificate has the lifector, page 2 s		25 Was case referred to medical	00 Birry of Brook		o 1 ☐ Yes	2□ No		
ding Physicien: h. After this certific funeral director,	o Be	examiner?	Othor		6 ∏Other (Specific	4)		
g Ph er thi	n.	27. Manner of Death 28a. Date of Injury 28b. Time of 2	8c. Injury at 2			,		
tendin death. tor: Aft the fun	atio	1 Natural 5 Pending (Month, Day Fear) Injury 2 Accident investigation M	1 ☐ Yes 2 ☐ No					
r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	, office 2	28f. Location (Street and Number or Rural Route Number,				
rs aft el Di	Cer			ony or rown, orac				
To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation.	at the time, date and place, ar	nd due to the cause(s	and manner as st	ated.		
the hin 2 the l	Med	and marmer stated.						
To Wil	-			29d. Da	(i. Month,	vay, rear)		
6		New Married   Married   Name						
ξ		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SRIDHAR AT LUPI, 8109 Ril the Hours	1; Ponaden	and MD	21122			
Sta	ite	31. Date filed (Month, Day, Year) 32 Registrar's Signature	1 (					
Registi		JUL 0 6 2004 Jane M. Sparke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 11:10 PM M 4005, Wilson Robert Myers Jr June /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Stella Maris at Mercy Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept 25, 1 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F Yrs. 56 Director 212<del>-</del>48-7930 Maryland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after death with the Marylar of Heatth and Mental Hygiene.
Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I.E. Madical Exist in an invariate notified at MD Anne Arundel 1 Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4931 Brookwood Road 21225 USA 12. Was Decedent Ever in U.S. Amed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 165-68 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laborer construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wilson Robert Myers Dorothy Lorraine Meldrom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: if item 27 Lorraine Myers/mother 3214 Rosalie Road Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State any injury once. \* 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ROITa Ld St Walk State Anatomy Board 655 W. Baltimore Street many 21201 Baltimore, MD Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Chuse (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2□No Hospital or Attending Physician; After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 User (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier D4085

State Registrar DHMH 17 Rev 1/2001

altimore, Maryland 21215-0036

P.O. I

Division of Vital Records,

S0 h

MD

32. Registrar's Signature

Paul

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sisepers.

0 6 2004

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #7 PER FH G833 7/066/00/6/cattle of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7:200m Day Vaar **Physician** 2001 YLMI 00 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number Examiner USA 9. Birthplace (State or Foreign last birthday) If Under 24 Hrs. 7. Age (In yrs. 5. Social Security Number **Funeral** M 2□F 5167 83 N.C Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be multified at Yos 2 □ No Md. NA Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 501 Preston Street 21202 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Black δ 3 ₩ Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Bethlehem Steel Corp. Unkn Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental Moose Nicholson Wattie ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3212 Barclay Street, Baltimore, Md. it of Health a Beatrice Murray Friend injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If Owings Mills, Md. Garrison Forest Vet. 7-6-04 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or commications that caused the dealing Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transi attending physician and Due to (or as a consequence of): Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the hould be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 2 No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 ☐ Yes 2 No oto 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending investigation 1 Natural 2 Accident 1 Tyes 2 No death filled in by the **Director:** 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier i 🕰 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month) Day, Year) 29c. License number 29b. Signature and title e Bldg, Ste 303. 32. Registrar's Signal 31. Date filed (Month, Day, Year) State Registrar 0 6 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Wanda Denise McNeill State of Maryland / Department of Health and Mental Hygiene 04 - 4211Certificate of Death **AKG** 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** McNeill Denise 3:20 ₽ Wanda June 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore County Woodlawn
If Under 1 Year | If Under 24 Hrs. 2010 Richglen Drive 8. Date of Birth (Month, Day, Year) 9-13-57 Birthplace (State or Foreign Country)
 MO . 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🕇 F Months Hours 46 219-62-0442 Yrs Director Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir then "natural", or items 23a or 28e-f show the Medical Extrailing fount to notified at Yos 2 No Director Woodlawn Baltimore Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Apt. 1-B 21207 USA 2010 Richglen Dr. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 

Never Married 2 

Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if itam 27 is marked other then 's any Injury or other treumetic event, the Magnus Jones. Elementary/Secondary (0-12) College (1-4or 5+) State of Md. Secretary 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carter McNeill Doris Roosevelt ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30 Royal Ann Ct., Baltimore, Maryland 21237 LaToya Magginson Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Arbutus, Md. Arbutus Mem. Park 7-2-04 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. 1101 E. North Ave. March F.H. East Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Inter the disease, or complication and the shock, or heart failure. List only one call on a Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran end Due to (or as a consequence of): Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ŏ 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f P. 0. 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2/2/No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼ / es 2 □ No 24a Was an page 2 certificate 2 No Yes of Vital director Be 26. Place of Death (Check only one) Other: Hospital: 1 Inpatient 4 Nursing Home 5 Residence 6 

Other (Specify) at scene 2 ER/Outpatient 2 3 DOA 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: After Division Hospitel or Attending 5 Pending investigation Natural 2 Accident 1 Tyes 2 No death. Director: / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 T Homicide thin 24 hours a the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely 113 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signat 2 June 28, 2004 O.C.M.E.

Registrar

State

31. Date filed (Month, Day, Year)

JUL 0 6 2004

DHMH 17 Rev 1/2001

111 Penn Street, Baltimore, Maryland 21201

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 1. Decedent's Nama (First, Middla, Last) 2. Data of Death **Physician** Margaret Anne Mallon July 2004 3:20p.m. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Parkville Baltimore 5. Social Sacurity Number If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) **Funeral** Birthplaca (State or Foraign Country) Months Davs Hours 1□M 2√2 F 215-03-3890 92 Director Mary Tand Usual Rasidance of Decedant the Marylend 10b. County 10c. City. Town or Location 10d. Insida City Limits ahow Maryland Baltimore 1 ☐ Yas 21 No Funeral Director Parkville or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? e filed within 72 hours efter deeth with al Hygiene. other than "natural", or items 23e or 8820 Walther Blvd. 21234 U.S.A. 11. Marital Status 12. Was Dacedant Evar in U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - Amarican Indian, Black, White, etc. 1 Naver Marriad 2 Married Yas 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by Specify. 3 Widowed 4 □ Divorced Specify: White Yaar or Datas: 15. Decedant's Education (Spacify only highast grada completed) 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 12 yrs. Homemaker Own home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) permit. Pages 1 and 2 should be f Depertmant of Heelth and Mental I Important: If item 27 is marked of Frank Patrick McGarvey Jenny McNicholas 19a. Informant's Nama/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, State, Zip Coda) J.Michael Mallon (son) 2521 Hunter Mill Road Oakton, Virginia 22124 20b. Place of Disposition (Nama of cematery, crematory or othar place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Removal from State any injury New Cathedral Cemetery 7/8/04 4 ☐ Donetion 5 ☐ Othar (Spacify) Baltimore, Maryland 21. Signature of Funarat Sarvice Licensee 22 Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Md. 23a. Part1. Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only one cause on each time. Approximete Interval Between Onset and Death **Physician** /Medical Immediata Causa (Finat diseasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Physician/Medical Examiner signed by the ettending physicien end d be detached for use as the buriel-transit Attending Physician: The law requires that the death certificeta be executed Sequantially list conditions, if eny, laading to immediata causa. Entar Underlying Cause (Disaasa or injury that initiated evants resulting in death) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yas 2 ☐ No 3 Probably 4 Unknown þ erel Director: Aftar this cartificate has been si filled in by the funerel director, page 2 should Be Completed 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 ☐ Yas 2 - No 1 ☐ Yes 2 ☐ No 25. Was case rafarrad to medical 26. Place of Death (Check only one) axaminar? Othar: Certification: To 1 Yas 2 No 1 🗆 Inpatiant 2 ER/Outpatiant 3 DOA 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Spacify) 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending м 1 ☐ Yes 2 ☐ No 2 Accident invastigation 3 Suicida 6 Coutd not ba 28e. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 4 Homicida within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledga, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifiar edicai

My+ Mellon

State Registrar

31. Data filed (Month, Day, Year) 0 6 2004

Bruner

29b. Signature and titla of certifiar

32. Registrar's Signatura

- WIL

30. Nama and address of person who complated cause of death (Item 23a) (Type, Print)

8800 oals

29c. Licensa number

29d. Date signed (Month, Day, Year)

pon

State Registrar

8

31. Date filed (Month, Day, Year)

lasha

29b. Signature and title of certifier

Lorsha

Greenberg

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) June 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

32 Registrar's Signature JUL 0 6 2004

Treenberg

			1 - For State Registrar	State of I	Maryland	-	artmen rtificat			and M		Reg. No	004	21071
10	Physici	an	1. Decedent's Name (First, Middle, L	•							2. Date of De. Month	Day	Yeer	3. Time of Death
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	Funeral		Social Security Number 6.		Age (In yrs. la:	st birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bin (Month, Da May /,	h y, Year)	9. Bir	thplace (State or Foreign
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	ylend		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
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	ne 23	eral	715 Country Vill	12. Was Decede	nt Ever in U.S.		Was Deced	2101 dent of His		gin? (Spe	cifv Yes or No	US.		erican Indian,
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pu	be flied with tei Hygiene. id other ther event, the M	Bec	17. Father's Name (First, Middle, Las								(First, Middle,		mame)	
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Ma	2002		Stephen P. Moor								<i>ive</i> Apt			, MD 21014
ore,	of Heeith of Heeith liem 27		20a. Method of Disposition		20b. Pla	ce of Dispo					ate		tion - City or	
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Ball	permit. Peges Depertment of I Important: If Its eny Injury or o		21. Signature of Funaral Service Lice  Thomas Grego	E L		22	remai 299 Fi	d Address tion ceder	Societick	ety ( Road	Of Mary Baltim	land ore.	Inc. MD 212	228
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of \	Physician: this cartific	2	1 ☐ Yes 2 127 No	Hospital: 1 Inpa		NOutpatien			4 🔲 1901		ne 5 Resid			cify)
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	9	4	30. Name and address of person who	CD8 M.1	>.	FA	Print) 2 UST	112	- M	ZLA AR	THAWD	SAD	210	47
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		For State Registrar	State of Marylan	•	ificate of			Reg. No.	004	21072
		1. Decedent's Name (First, Middle, L	Last)	•			2. Date of Do	eath Day	Year	3. Time of Death
Physicia		Grace Louis	se McPherson						2004	6:30a
/Medic Examin		4a. Facility Name (If not institution, g	give street and number)	4	4b. City, Town, o	r Location of Deat	h	4c.	County of Deet	th
		Carroll Hospital	l Center		Westmi	nster			arroll	
Funeral Director		5. Social Security Number 6. 212–12–5559	. Sex 7. Age (In yrs. 1		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.				thplace (State or Fore ountry)
<b>P</b>		Usual Residence of Decedent	100 Cit	ty, Town or Loca	ation.					10d. Inside City Lim
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or items 23a or 28e-f show any Injury or other traumatic avant. In Medical Expirator, until to indiffed alonge.	_	Md Baltin		istersto						1 □ Yes 2 □
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de met	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	10-	Black, Whit	
5	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates:	10	☐Yes 2☐No	Specify:			Specify: bla	ack
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le m		19a. Informant's Name/Relationship Richard Lockhart		•						
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certifice		1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of	3 DOA	4   Nursing	Home 5 Re			<del>sciry)</del>
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Hospitel or Attending Phy 4 hours after death. Funaral Diractor: After this ely filled in by the funeral d	edical Certification;	29a. Certifler (Check only one)  29b. Signature and title of certifler  30. Name and address of person w	physician: To the best of my krixaminer: On the basis of examinand manner stated.  The physician of the basis of examinand manner stated.  The physician of the basis of examinand manner stated.  The physician of the basis of examinand manner stated.	nowledge, death nation and/or invo	estigation, in my  29c. Licen  Control	opinion, death occurse number	curred at the time	29d. Da	te signed (Mon	nth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month MATTHEWS 0326 AM TRANCES 2004 JUL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MODICAL COMPR BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min. Days 213-52-1472 1 ☐ M 256F Months 53 Director Usual Residence of Decedent death with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location itam 27 is marked other than "natural", or items 23e or 28a-f show other traumatic evant. Ite Medical Examinat must be notified at 1 XYes 2 No Funeral Director Ma timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? C.A. 21230 U.S.A ace 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 StNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or iten any injury or other traumatic evant, the Medical Examples once. Black, White, etc. 1 Never Married 2 Married Specify: Black Saltimore, Maryland 21215-0036 1 Yes 20 No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 acker 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type, 19b. Mailing Adjress (Street and Number or Rural Route Number, City or Town, State, Zip Code) apr 101 Balto. hawvence rchand 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 R 3 Removal from State 7.2004 21. Signature of Funeral Service Licensy Douglas Balto. ulloh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACIDEMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** He patitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of) the burial-transi that initiated events the attending physician and thed for use as the burial-tran resulting in death) Last law requires that the death certificate be exec Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? (es 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one, 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Thpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospitel or Attending I within 24 hours after death. To the Funeral Diractor; After 5 Pending investigation 1 Matural 1 🗌 Yes 2 No 2 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a To the Funeral C 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P17657 MD 2,2004

Registrar

State

32. Registrar's Signature 31. Date filed (Month, Day, Year) JUL 0 6 2004

MANNO

ReBECCA

30. Name and ad 15 s of person who completed cause of death (Item 23a) (Type, Print)

MD

33 South Greene Street Bactimore, MARYAND 2120

		-	For State Registrar		State of	Maryland		artment <i>tificate</i>			and M		giene	C C :	21	074
			Decedent's Name	(First, Middle, Last)						,		2. Date of Dea	ath Day	Year		ime of Death
#	Physicia /Medic		Verna M	. Moeller								July 1	, 20	04	6	:45 A M
	Examin		4a. Fecility Name (If			ber)		4b. City, T			of Death		4c.	County of De Balti		
			Augsbur  5. Social Security Nu	g Luthera		. Age (In yrs. las	t birthday)	If Under 1		If Under:		8. Date of Birt	h			State or Foreign
.6.	Funeral Director		217-07-	10	M 25€F	90	Yrs.	Months	Days	Hours	Min.	(Month, Da) 2/17/1	912		Mary1	and
	D		Usual Residence of D	Decedent		10c City	Town or Lo	eation							10d. Ins	side City Limits
	arylar	5		10b.County Baltimore			chear									]Yes 2 ⊠ No
	the M 28e-f	ecto	10e. Street and Num					10f. Zip (	Code				10g. Citi	zen of What (	Country?	
	a or	Di		mpfield R	oad				207					U.S.A.		
	death	nera	11. Marital Status			ent Ever in U.S.	13.	Was Decede	ent of His	panic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race - An Black, Wh		ian,
98	or ite	by Funeral Director	1 Never Marrie		1 Tyes 2 If Yes, Give Year or Dal	2 <b>X</b> No		1 ☐ Yes 2		Specify:				Specify:	White	
Ş	within 72 hours after death with the Maryland one. Than "natural", or Items 23a or 28e-f ahow fa Medical Exa: in ar mual be notified at	ed b	3 🗌 Widowed 4	15. Decedent's Edu			16a. Dece	dent's Usual	Occupat	tion			16b. Ki	ind of Busines	s/Industry	
15	n "na Nedic	Completed	(Specification (Speci	fy only highest grade	ocompleted)	4or 5+)	(Give life.	kind of work DO NOT us	k done du e retired)	uring mos	t of work	ing			_	
212	e filed within al Hygiene. I other than 'vent, tra Me	Com			College (1-	,	Mu	sicia						1f Emp	loyed	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. I Health and Mental Hygiene I Health and Mental Hygiene I Health and I Health and I have a state of the transition of the I hadical Exactional transition in the Indical Exaction of the Indical E	Be	17. Father's Name (F									e (First, Middle, t Riehl	, Maiden	Sumame)		
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Ma	nd 2 silth an lith an 27 is r			Berends	p=, ,		7 C1	emint	ine	Ct.	Apt2	6 Balti	more	, Mary	land	21237
re,	other tr		20a. Method of Disp		land and from C	l cor	ce of Disponetery, cre	osition (Nam matory or ot	e of her place	)		Date	20c. Lo	ocation - City	or Town, S	tate
E O	Pages nent of ant: If its ary or o		° 4 ☐ Donation	Cremation 3 □F 5 □ Other (Specify)		Pa	rkwoo				7/3			timore		•
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Fur	neral Service Hoen's	98 777	MOOS						ller-Di altimor				me Inc.
E	4		23a. Part1. Enter the shock, or hear	e disease, or compl t failure. List only o	ications that ca	ich line.							rrest,		Inter	oximate val Between et and Death
	Physician		Immediate Cause (I		Att	orosci	erot	ic He	art	- Di	Sea	1200				nuntles
	/Medical Examiner		resulting in death)		Due to (d	or as e conseque	ence of):									
45	5.4	- a	Sequentially list con		b. Due to (c	or as a conseque	ence of):									
	uted d ansit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or i that initiated events	injury	c											
oʻ	te be executed ysician and ne burial-transit		resulting in death) L			or as a conseque	ence of):									
3760,	ate be hysicia the bu	Ilcal		•	d											
x 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:		23c If yes out	come of pregnan	cv							23d. Date of	delivery	
Box	attend for us	cian	23b. Was decedent in the past 12	months?	1☐Live bi	rth 2 ☐ Fetal o	death 3	□Ectopic pro						Month	Day	Year
o.	that the de led by the a detached t	ysic	1 □ Yes 2 0 9 □ Unknown	ano .	9□ Unkno	wn						-			_	
ď.	uires that signed b d be deta		Part II. Other signifi	icant conditions co	ntributing to de	ath but not resul	ting in the I	underlying ca	ause give	n in Part	1.			use contribute		
rd	w require been sig should b	ted	<u>11 y</u>									10	Yes 2		Probably	4 Unknown
Records,	e law r has be je 2 sh	Completed by										24a. Was		24b. Were prior death	autopsy fil to completi	ndings available on of cause of
E H												1 ☐ Yes	2 1 No	1 T		<b>6</b>
Vital	Physicien: The this certificate ral director, pag	Be C	25. Was case reference examiner? 1 ☐ Yes 2 ☑	/	Hospital:	npatient 2 🗆 E	R/Outpatie	ent 3 🗀 DC	Othe	/		th (Check only) ome 5□Res		6 DOther /S	pecify)	
ठ		n; To	27. Manner of Deat	h	_		28b. Time		8c. Injury Work	A	ursing ric	28d. Describe			poony	
<u>io</u>	Attending For death.  ector: After by the funer	atio	1 ☐Natural 2 ☐ Accident	5 ☐ Pending investigation		II, Day 16ai/	irijury	M		Yes 2	No					
Division	r Atte ter de irecto	Certification;	3 🔲 Suicide 4 🗀 Homicide	6 Could not be determined	200. Place	of Injury - At hor ng, etc. (Specify)	ne, farm, s	treet, factory	, office			28f. Location City or To			Rural Rou	te Number,
Q	ors aff		00- 0	1 Certifying Phy	raining. To the	hast of my know	dodao dos	th oneurod	at the tim	o data a	nd place	and due to the	causa/s	and manner	as stated	
	To the Hospitel or Attence within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one)	2 Medical Exam	rsician: To the bailiner: On the bailiner and manr	asis of examinati	on and/or i	nvestigation	, in my or	oinion, de	ath occur	rred at the time	date an	d place, and	due to the	cause(s)
	To the within To the comple	Me	29b. Signature and	title of certifier						number	,			ate signed (Mi	-	3 P
	/		> Lell	per I	Leen	_			•	931				Y 1.		
	6		30. Name and addr	ress of person who can I	completed caus	e of death (Item	23a) (Type	Print)	que	Ave	nu	e fal	hme	ove Mi	0 21	208
	St Regist	ate trar	31. Date file	0 6 2004	52. R	egistrar's Signat	ure G	la.								

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 0823 PM <u> William Patrick O'Brien</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. AGUES Social Security Number Healthcare TIMOVS Year If Under 24 firs. N/A 8. Date of Birth (Month, Day, Y Mar 13, 1 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1**∑**M 2□F Months Days Hours Maryland 70 Director 219-30-7083 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 27 is marked other than "natural", or Items 23c or 28a-f shov traumatic event, the Medical Experience must be explited at 1∑Yes 2 No N/A Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3330 Wilkens Avenue 21229 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1.2 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 10 Laborer Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William P. O'Brien Agnes T. Zilonka ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 if Health item 27 Jane M. Bowen/ Sister 19 Woodlawn Avenue Catonsville, MD 21228 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of I 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) = permit. Page Department of Important: If any injury or once. 7/5/04 Metro Crematory Inc. Baltimore, MD Thomas Gregor 21. Signature of Fu Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician cardiorascular discase acterioscherotic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-tran certificate be exec Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2X No 1 Inpatient 2ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending investigation Injury 24 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 the 29b. Signature and title of certifier moun

State

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

1. Date filed (Month, Day, Year)

JUL 0 6 2004

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State	State of M	arylan		partment of F		lental Hy	/giene	0.01	
			Registrar				ertificate of	Death		Reg. No.	004	21076
	Physici	an	Decedent's Name (First, Middle						2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	Henry Berr			r.	4h Cihi Taum	r Location of Death	July 4	2, 20	04 County of Death	10:00 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution					timore		46. (	N/A	
	Funeral		Joseph Rich 5. Social Security Number	ey Hospice 6. Sex 7. Ag	je (In yrs. I	ast birthda	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth .		place (State or Foreign
	Director		404-26-5360	X□M 2□F	79	Yrs	Months Days	Hours Min.	Oct 9.	ау, Year) • 1924	4 Ker	ntucky
	pu ,		Usual Residence of Decedent		10.00							
	arylar show	_	10a. State 10b. County	<b>-</b>	10c. City		Location				"	10d. Inside City Limits
	8a-f	Scto	- all y Laria	ltimore		Ва	altimore					1 ☐ Yes 2 ☐ No
	with t	D.	10e. Street and Number	<b>A</b>			10f. Zip Code	0.0		10g. Citiz	en of What Cou	ntry?
	eath	Funeral Director	4304 Highview	AVENUE  12. Was Decedent	Ever in U.:	S. 1	212		acify Yes or N	0- 1	USA 4. Race - Americ	ran Indian
10	r Iten	표	1 Never Married 21 Marri	Armed Forces?	?		<ol><li>Was Decedent of H If Yes, specify Cuba</li></ol>		Rican, etc.)		Black, White,	
036	hours after death with the Maryland lural', or Items 23a or 28a-f show al Evartinar mual be notitied at	þ	3 Widowed 4 Divorced	ed 17 Yes 2 1 If Yes, Give Year or Dates:	43-46		1 □ Yes 2 No	Specify:			Specify: W	nite
2-0	72 hours "natural",	Completed	15. Decedent (Specify only highes	s Education		16a. De	ecedent's Usual Occupive kind of work done	pation during most of worki	na	16b. Kin	d of Business/In	dustry
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2	iled w Hygiei ther ti		17. Father's Name (First, Middle, I	) J			Distille	18. Mother's Name	/First Middle	Maidan	Managen	ent
and	otal ted of	Be	Henry B. Pa								surname)	
Z	should ad Me mark matic	ဥ	19a. Informant's Name/Relationsh			19b. Ma	ailing Address (Street		Ehrir	<del></del>	Town State Zir	Code
Z	nd 2 s Ith an 27 is trau		Gertrude Paslic				4 Highview			l-can a	1702011202011	, 0000)
G é	s 1 ar f Hea f Hea ttem other		20a. Method of Disposition	N/ WIIC	20b. Pl	lace of Dis	sposition (Name of crematory or other place		ate Lation		21229 ation - City or To	own, State
5 5	nit. Pages 1 and 2 should be filed within 72 ho artment of Health and Mental Hygiene. ortant: If Hem 27 Is marked other than "natur injury or other traumatic avant, Ira Madical g.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp				cematory I		/04	Bal	Ltimore,	MD
$\mathcal{Q}$ ( $\mathcal{O}$ $ ho \mathcal{P} \mathcal{M}$ Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic avant. If a M. Once.		21. Signature of Funeral Service I			1	22. Name and Addre	,	of More			. 115
() m	Depa Impo any i		Thomas Grego	7			299 Freder	rick Koad	nary Baltin	ore.	MD 2122	8
<del>-</del>	M.		23a. Part1. Enter the disease, or shock, or heart failure. List		d the death	. Do not	enter the mode of dyir	ng, such as cardiac c	r respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Len	y he	1	tementia					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):	1 1					7-402
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	e deal	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			5 Other (specify)				Month	Day Year
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Jec	e law has l	Completed							24a. Was		24b. Were auto prior to co death?	psy findings available mpletion of cause of
a 3	sician: The law certificate has l irector, page 2 s		05 111						1 ☐ Yes	2 No	1 🗆 Yes	2 <b>12</b> No
<u>`</u> _;	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	ent 2 🗆 l	ER/Outpo	tient 3 DOA Oth	26. Place of Death en: 4 ☐ Nursing Hor			Hanne 10000	Hornica
2 40		n: To	27. Manner of Death	28a. Date of Inju		28b. Time	e of 28c. Injur	y at 2	28d. Describe			ni i spice
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4e Division	r Attend er death rector: A by the f	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		jury - At ho	me, farm,	street, factory, office	2	28f. Location (	Street and wn, State)	Number or Rura	I Route Number,
Ö	italours aft	Cer										
	Hosp 4 hou Funal ely fil	edicai	(Check only 2 Medical I	g Physician: To the best Examiner: On the basis o	of examinat	wledge, de ion and/or	eath occurred at the tir r investigation, in my o	ne, date and place, a pinion, death occurre	and due to the ed at the time,	cause(s) a	and manner as st	ated. the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the fu	Med	one)  29b. Signature and title of certifier	and manner st	ated.		29c, Licens				signed (Month,	
	T W T		5-10-	10								
	1		30. Name and address of person	who completed cause of c	death (Item	23a) (Tu	ne Print\	1170		Jul	y 2, 10	7
	\		E.Ta MD K	icher Haspic		838	DE N. Euta	wSt Ba	1timo	re. M	D 212	01
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	_=	ture			- 0 0 0	- / · V		
	Registr	ar	JUL 0 6 2004	Sensera	1	9	Sparks					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Day Year **Physician** July 2004 James C. Phelps /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville

| If Under 1 Year | If Under 24 Hrs. |
| Months | Days | Hours | Min. | Catonsville Commons Baltimore 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**]M 2□F Yrs. 227-01-1458 93 Director Jun 11. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, it e Medical Examinat must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 💆 No Maryland Baltimore Directo Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 16 Fusting Avenue USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Shipyard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Ann Sansome Martin V. Phelps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1235 Oakland Terrace Road Baltimore, MD 21227 <u>Janice C. Cronise / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 7/3/04 <u>Baltimore, MD</u> 21. Signature of Funeral Service Licensee

Home Thomas Gregor <sup>22</sup> Name and Address of Facility
Cremation Society Of Maryland Inc.
299 Frederick Road Baltimore, MD 21228 Approximate Interval Betwe Onset and De 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** eus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à this certificate has been signeral director, page 2 should be and 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy periomed? 2 No 1 Yes 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2⊠ No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation after death 2 ☐ Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital -within 24 hours a: To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 30. Name and address of person who completed cause Blud. 303 1001100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 6 2004 Registrar

			State of M	1arylan	nd / Dep		f Health	and Menta	l Hygie	_	ΩL.	21078
	Physici	an.	1. Decedent's Name (First, Middle, Last)					2. Date Mor	of Death	Day	Year,	3. Time of Death
	Physici /Medic		Dorothy May Phelps					Ju	14	1 2	2004	6:44 AM
	Examin	er	4a. Facility Name (If not institution, give street and number	101	1	4b. City, Tow	m, or Location	i 0	<i>'</i>	4c. Count	y of Death	i mosp
	Funeral		The state of the s	- 11	last birthday	If Under 1 Ye			of Birth		9. Birtho	place (State or Foreign
	Director		216-16-1820 ¹□M 282F	8	O Yrs.	Months Da	ays Hours	Min. Oct	of Birth hth. Day, Y	1923	Mass	achusetts .
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or L	ocation						10d. Inside City Limits
	Maryla f sho	ō	Maryland Baltimore		sex							1 ☐ Yes 2XXXVo
	r 28a	irect	10e. Street and Number	По	<u> </u>	10f. Zip Cod	de		100	g. Citizen of	What Cour	ntry?
	th with	aiD	945 Barron Avenue			2	1221		U	.S.A.		
	hours after death with the Maryland tural', or Items 23e or 28e-f show Exstricet must be rediffed at	Funeral Director	11. Marital Status 12. Was Deceder Armed Forces	s?	l.S. 13.	Was Decedent If Yes, specify C	of Hispanic Or Cuban, Mexica	rigin? (Specify Year, Puerto Rican, e	or No-		ce - Americ	
36	rs afte	by Fu	1 Never Married 2 X Married 1 Yes 3 If Yes, Give 1 Year or Dates			1☐Yes 2☐				Speci	fv:	
~ i	2 hou	ted t	15. Decedent's Education	•	16a. Dece	edent's Usual Oc	ccupation		16	6b. Kind of E		ite
215	thin 72 9. 9. "na Medi	pie	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4o)	r 5+)	(Give	e kind of work do DO NOT use re	one during mo etired)	st of working				
10	ed will ygien ner th	Completed	12		Secre	etary				tate I		tment
S, D o (6th) Maryland 21215-0036	uld be fill Jental H irked oth	To Be	17. Father's Name (First, Middle, Last) Walter Driscoll					er's Name (First, Young	Middle, Ma	aiden Sumai	me)	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, it we Medical Exertiret must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Thomas E. Phelps (Husband)					er or Rural Route , Essex,				Code)
$\rho$ h e / Baltimore,	of He of He if item or other		20a. Method of Disposition 1 □ Burial 2000 remation 3 □ Removal from State		Place of Disp cemetery, cre	osition (Name or ematory or other	place)	Date		c. Location		
Ë >	. Pag tment tant:		*4 □Donation 5 □Other (Specify)	Ba		Cremato	- 1	July 5,20	5.			
Bal	permit Depar Impor any in	_	21. Signature of Funeral Service Licensee		2	2. Name and Ad	dress of Facil Bruzdz	inski Fu	neral	Home	P.A	
			23a. P.m.1. Enter the disease, or complications that cause hock, or heart failure. List only one cause on each	ed the deat		140 / OI	a East	ern aven	æ, E	ssex,	Mary.	Land 21221 Approximate
	Physician '		In mediate Cause (Final	Bridge Street		irato	^ -	arres			-	Interval Between Onset and Death
	/Medical		resulting in death)  Due to (or a			11000	7	11/67				
1	Examiner	L	Sequentially list conditions, b. A 5 y 5	+61	9							
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	s a conseq	quence of):							
	be executed ician and burial-transil	Examiner	that initiated events resulting in death) Last c. Due to (or a	is a conseq	quence of):	00						
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9	tificat ng phy as th	Medi	1555.111.5									
Вох	leath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mynths?  23c. If yes, outcom			□Ectopic pregna	ancy				ate of delive	
	ne dea the at	/sici	1   Yes 2 2 No 9   Unknown 9   Unknown		death 5	Other (specify	v)			IVI	onth	Day Year
P.O.	res that the de igned by the a be detached t		Part II. Other significant conditions contributing to death	but not res	sulting in the I	underlying cause	given in Part	I. 23e	. Did toba	cco use con	tribute to th	he cause of death?
$\stackrel{ extstyle \times}{ imes}$ Division of Vital Records,	S 75 90	d by							1 🗌 Yes	2 Z No	3 🔲 Prob	pably 4 Unknown
ō	> 0 0	ojete						248	. Was an	24b.	Were auto	psy findings available
Re	9 - 9	Completed							autopsy performe Yes 2	ed? Z No	prior to condeath?	mpletion of cause of 2□ No
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of V	phys this al di	P.	1 Yes 2 No Hospital: 1 Inpa  27. Manner of Death 28a. Date of In		ER/Outpatie	III JUDOA		ursing Home 5[				y)
u o	ding J. After tune	tion	Natural 5 Pending (Month, D	Jay Year)	28b. Time of Injury		Injury at Work? 1 ☐ Yes 2 ☐		cribe now	injury occu	rred	
/isi	Attending r death.	ifica	3 Suicide 6 Could not be determined 28e. Place of I	njury - At h	ome, farm, st	reet, factory, offi		28f. Loc	ation_(Stre	et and Numi	ber or Rura	I Route Number,
火点	s after s after al Dire	Certification;	4 Homicide determined building,	etc. (Specif	fy)			City	or Town,	State)		
	To the Hospital or Attenwihin 24 hours after deatl To the Funeral Director:	Medical	29a. Certifier (Check only one)  Certifying Physician: To the besidence of the desirence of	of examina	owledge, dea ation and/or in	th occurred at the	ne time, date a my opinion, de	nd place, and due ath occurred at the	to the cau time, date	se(s) and m e and place,	anner as si and due to	ated. the cause(s)
_	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Lic	cense number		290	l. Date signe	ed (Month,	Day, Year)
	1.		+ father curry, ms				556.	)5		7/1	120	74
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100	- 01		31. Date filed (Month, Day, Year) 32. Regis	strar's Signa	ature	n 394	ME	NING	Da	1111	1016	MY 21237
	Sta Registi		31. Date filed (Month, Day, Year) 32. Regis	مايد	Li	į.						

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	/Medio		Ralph 4a. Facility Name (If not institution		r)		4b. City, Tov				D 1007 41	T	ty of Dea		<i>□</i>   <sup>m</sup>
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	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "neturel; or itams 23e or 28e-f show event, the Medical Exam her must be notified at	era	519 Radnor Av	12. Was Deceden	t Ever in U.	.S. 13. 1	Was Decedent		_	n? (Spec	cify Yes or No-			erican Indian,	
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21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates	:							Spec	I	Black	
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ğ	e filed Il Hygi othar vent,	BeC	17. Father's Name (First, Middle,								(First, Middle,				
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lar			19a. Informant's Name/Relations				•				Route Numbe	. ,		. ,	
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Baltimore,			<b>™</b> Burial 2 ☐ Cremation		<b>3</b>		sition (Name of natory or other					20c. Location			
뜶			<ul> <li>4 □ Donation 5 □ Other (S</li> <li>21. Signature, of Funeral Service</li> </ul>		Ga						/6/04	Owing	s M:	ills,	Md
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			23a. Part1. Enter the disease, or shock, or heart wilure. List	complications that cause only one cause on each	ed the deat line.	h. Do not ent	er the mode of	dying, s	such as ca	ardiac or	respiratory are	rest,		Approxima Interval Be Onset and	tween
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S TVOF	2- N	ONTN	SHI TM	DEI	DENIN	ENT	DIABE	rec			
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8760,	ate be executed hysician and the burial-transit	dical		d	MELL	ITUS									
9	entific ling p	Mec	IF FEMALE:	00. 1/											
Вох	The law requires that the death certificate be executed tto has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth 4☐Pregnant	2 Feta	Ideath 3□	Ectopic pregn						ate of deli Ionth	,	Year
o.	by the destached	nysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	at time of d	eath 5L	JOHNER (Specif)	y/							
<b>Q</b>	res that igned b be deta	by Pt	Part II. Other significant condition	ons contributing to death	but not res	ulting in the u	nderlying cause	e given i	in Part I.		23e. Did to	bacco use cor	tribute to	the cause of	death?
Vital Records,	v requires been sig should b	ed b									1 X	es 2 🗆 No	3 🗌 Pr	obably 4 🗆	Unknown
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Ä	: The l cate ha	E O				-				_	autop: perfor	med? 2 <b>X</b> lo	death?	completion of a	ause of
/ita	ician: certific rector,	Be (	25. Was case referred to medical examiner?						6. Place of	f Death	Check only or				
1 Department 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec									cify)						
	ng fee	tion	27. Manner of Death  1 Natural 5 Pendin investig		ay Year)	28b. Time of Injury		Injury at Work?	t s 2 ⊡No		3d. Describe h	ow injury occu	rred		
Division	or Attanding after death. Director: Afte in by the fune	fica	3 ☐ Suicide 6 ☐ Could	not be	njury - At ho	ome, farm, str			5 2	_	Bf. Location (S	treet and Num	ber or Ru	ral Route Nun	nber.
27. Manner of Death 1															
	Hospital 14 hours (17 hours (18 hours) (19 hours) (19 filled)	Medical	(Check only 2 Medical	g Physician: To the bes Examiner: On the basis	of examina	wledge, death tion and/or inv	occurred at the	ne time, my opini	date and p	place, ar	nd due to the c	ause(s) and m late and place	anner as	stated. to the cause(s	s)
The state of the s															
								711-0	.   .	28/20	04				
7	11/		30. Name and address of person	who completed cause of	death (Item	23a) Pvpe		===	000			المن ر	0	10/00	7
	A.,		ITLIA CERALI	OS. M.D.	760	7 //	FR DRI	r u F	_ 70	WSO	N. MAE	YLAND	213	2014	
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	Registr	ar	JUL 6	2004	40.0	H A	ack .								

Jessica Perez 04-4258 MAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland	I / Denartment of He:	alth and Mental Hygiene
State of Maryland	i / Department of Flor	aith and montain gion

1	-	For State Registra	r
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Physician
/Medical
Examiner

**Funeral** Director

"natural", or Itams 23c or 28a-f show

Pages 1 and 2 should be filed within 72 hours aftar death with tha Maryland permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natur any injury or other traumatic avant, the Medical once.

> Examiner been signad by the attending physician and should be detached for use as the burial-transit Be Completed by Physician/Medical Medical Certification: To

To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 **Physician** /Medical **Examiner** The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: completely filled in by the funeral within 24 hours after death. To the Funeral Director: After

Location Name   First Mattor   Location	For State Registrar		Certificate of Death	Reg.	₩5 U U [	21080
46. Colly, Name (if not institution, give street and number) 1000 Hilltop Circle 584-83-6832 1   M 2   Z   26   Vs.   26		ast)			Davo a a . Year	3. Time of Death
Cotonsville   Baltimore   Security Number   S. Sex	Jessica Soto	Perez		June 29	, 2004	1930 Р м
Second Security Number   Second Security Number   Second Security Number   Securit	4a. Facility Name (If not institution, g	ive street and number)	4b. City, Town, or Location of	f Death	4c. County of Deat	h
Use   Beachers   Decoders   Dec	1000 Hilltop Ci	rcle	Catonsville		Baltimo	re
106. Clory Town or Location   107. Supremand   106. Clory Town or Location   107. Expected   108. Street and Number   108. Street   108. St		- T-+ - O/	Months Days Hours	Min. (Month, Day, Ye	9. Birt Co 1977 Puer	hplace (State or Foreign untry Aquadilla to RICO
Maryland   Baltimore   Owings Mills   1   1   1   1   1   1   1   1   1		100 City Town	n or Leastion			10d Incide City Limits
11. Marital Status						1 ☐ Yes 2X No
1   Yes   2   No   Specify   Hispanic   1   Yes   2   No   Specify   1   Yes   2   No   Spec	# 4 Bitterroot (	Court Apt. B	10f. Zip Code 21133	_		untry?
1   Yes   2   No   Specify   Hispanic   1   Yes   2   No   Specify   1   Yes   2   No   Spec	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Orig	nin? (Specify Yes or No-		
15. Decedant's Education (Specify only highests grade completed)   16a. Decedant's Usual Occupation (Give kind of working) (file kind of kind o	1 Never Married 2X Married	If Yes, Give				
Full time student   Maryland	15. Decedent's		Decedent's House Cocupation	of working		_ *
Antionio I. Soto  10a. Informant's Name (First, Middle, Maxien Sumame)  Luz Nereida Perez  10a. Informant's Name/Relationship (Type, Print)  Luz Nereida Perez (Mother)  10b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code)  10c. Location - City or Town, State, Zip Code Condended or Complete or Complet	Elementary/Secondary (0-12)					01
19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)  Luz Nereida Perez (Mother)  10b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)  Luz Nereida Perez (Mother)  20c. Method of Disposition 1   Burnal 2   Coremation 3   Removal from State 4   Donation 5   Other (Specify)  Pepino Memorial Park July 6, 200 4 San Sebastian, Ric 21. Signayure of Funeral Service Licensee  22. Name and Address of Facility Loring Byers Funeral Directors, 8728 Liberty Rd. Randallstown, MD 21133-4784  23a. PM. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line.  23a. PM. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  23b. PM. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  25c. Name and Course (Final disease or condition resulting in death)  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Was decedent pregnant in the past 12 months? 1   Wes 2   No 3   Probably 4   Dinknown  25c. Was an autopsy linknown  25c. Was case referred to medical examiner?  25c. Was case	17. Father's Name (First, Middle, La					
Comparison   Com	Antionio I. So	oto	Luz	Nereida Per	ez	
20a. Method of Disposition 1   Bural 2   Cremation 3   Removal from State   Pepino Memorial Park   July 6, 200   San Sebastian, Ric   21. Signayre of Funeral Servige Licensee   Pepino Memorial Park   July 6, 200   San Sebastian, Ric   22. Name and Address of Facility Oring Byers Funeral Directors, 8728 Liberty Rd. Randallstown, MD 21133—4784   23a. Plant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25. Name and Address of Facility Oring Byers Funeral Directors, 8728 Liberty Rd. Randallstown, MD 21133—4784   25a. Plant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, if any, leading to immediate Cause (Final death)   25. Due to (or as a consequence of):  26. Due to (or as a consequence of):  27. Due to (or as a consequence of):  28. Was decedant pregnant in the past 12 months?  29. Was decedant pregnant in the past 12 months?  29. Was decedant pregnant in the past 12 months?  29. Was decedant pregnant in the past 12 months?  29. Was decedant pregnant in the past 12 months?  29. Was decedant pregnant in the past 12 months?  29. Was decedant pregnant in the past 12 months?  29. Was decedant pregnant in the past 12 months?  29. Was decedant pregnant in the past 12 months?  29. Was decedant pregnant in the order of pregnancy in the underlying cause given in Part I.  29. Did tobacco use contribute to the cause of death?  29. Was an autopsy princings availage profit to completion of cause of death?  29. Was an autopsy preformed?  29. Was an autopsy princings availage profit to completion of cause of death?  29. Was case referred to medical examine?  29. Was case referred to medical exa	19a. Informant's Name/Relationship	(Type, Print) 19b	. Mailing Address (Street and Numbe	r or Rural Route Number, C	ity or Town, State, 2	Zip Code)
1   Bural 2   Cremation   3   Removal from State   Pepino   Memorial Park   July 6, 2004   San Sebastian, Ricc   21. Signature of Funeral Service   Licensee   22. Name and Address of Facility   Loring   Byers   Funeral Directors,   8728   Liberty   Rd.   Randallstown, MD   21133-4784   232   PM.   Errist the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between onset and Death   Sease or complications are consequence of  :	Luz Nereida Pere	z (Mother) HO	C-3 28365 San Seb	astian Puerto	00685	
23a. Pt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last    Due to (or as a consequence of):	1 Burial 2 Cremation 3	XRemoval from State cemeter cify) Pepino	my, crematory or other place)  Memorial Park  22. Name and Address of Facility	uly 6, 2004 S <b>Loring Byers</b>	an Sebast <b>Funeral I</b>	cian, Rico Directors,I
Sequentially list conditions on each line.  Due to (or as a consequence of):  Due to (or as a consequence of	Joseph & Nel	20/00				
IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 3   Probably 4   Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  1   Yes 2   No 3   Probably 4   Unknown  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other   A   Nursing Home 5   Residence 6   Mother (Specity)   On Scelegible   Sce	23a. Phor1. Enter the disease, or co shock, or heart failure. List on	ily one cause on each line.				Interval Between
Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Due to (or as a consequence of):	disease or condition	- Multiple	gushot won	rds		
Due to (or as a consequence of):    Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   Cause (or as a consequence of):	resulting in death)	Due to (or as a consequence	of):			
that infliated events resulting in death) Last    Due to (or as a consequence of):   D	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	of):			
23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 3   Probably 4   Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death? 1   Yes 2   No 3   Probably 4   Unknown  24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4   Unknown  25. Was case referred to medical examiner? 1   Yes 2   No 3   No 3   Probably 4   Unknown  26. Place of Death (Check only one)  Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)   On SCEI	that initiated events	c	of):			
23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death? 1   Yes   2   No   3   Probably   4   Unknown    24a. Was an autopsy performed? 1   Yes   2   No   No   No   Year    25b. Was case referred to medical examiner? 1   No   No   No   No   No   No   No    26c. Place of Death (Check only one)		d				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death				
24a. Was an autopsy findings availa prior to completion of cause of death?  25. Was case referred to medical examiner?  1X Yes 2 No  26. Place of Death (Check only one)  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Cher. 4 Nursing Home 5 Residence 6 Check (Specify)  On SCEI		s contributing to death but not resulting i	n the underlying cause given in Part I.			
25. Was case referred to medical examiner?  1X Yes 2 No  1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Mother (Specify) On SCE				autopsy performed	prior to death?	completion of cause of
examiner?  1X Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Mother (Specify) On SCE				1X Yes 2□		2 No
1 Inpatient 2 EMOutpatient 3 DOA 4 Nursing Home 5 Hesidence 6 Exother (Specify)	examiner?	Hospital:	Other		a 6 <b>X</b> O+b/0	On scene
	1X Yes 2 No 27. Manner of Death	1   Inpatient 2   EH/Ot	itpatient 3 DOA 4 INU			city) OII SCOILC

1 Natural

2 Accident

3 Suicide

4 Homicide

29b. Signature and title of certifier

29c. License number

t 🗆 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

voo Hilltop Girele, Catonsville,

O.C.M.E.

June 30, 2004

cause of death (Item 23a) (Type, Print)

5 Pending

investigation 6 Could not be determined

111 Penn Street, Baltimore, Maryland 21201

State Registrar 32. Registrar's Signature

2004

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Year

3. Time of Death

45 AM

q.

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

day

23d. Date of delivery

1 Yes

Day

3 ☐ Probably 4 ☑ dnknown

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Year

Month

1 Yes 2 No

2004

Baltimore

14. Race - American Indian, Black, White, etc.

White

Country)

Physician
/Medical
Examiner

1 - For State Registrar

**Funeral** Director

filed within 72 hours after death

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

1. Decedent's Name (First, Middle, Last) PERKINSON MILDRED EMMA Month JULY 02 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Magnolia Manor Assisted Living Catonsville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 22, 1918 Days Hours Min. 1□ M 2√2 F 215-01-7374 86 Yrs May Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f ehow the Medical Examinar must be notified at MD Howard Ellicott Gity .... Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 2540 North Farm Road USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: 1 Yes X No ģ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic and Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emory Adkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Donna L. Feher (Daughter) 2540 North Farm Road Ellicott City, MD 21042 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 TCremation 3 Removal from State
4 Donation 5 Other (Specify) All County Cremation 7/3/2004 Sykesville, MD 21. Signature of Funeral Service Licensee HATCHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that wised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): STRUKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Deceasor july that initiated events Due to (or as a consequence of): Examine burial-transit RTERIO PLEROTIC CEREBROVASCULAR DISEAS and resulting in death) Last Due to (or as a consequence of). attending physician for use as the buria Physician/Medical the use as i IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 4 Pregnant at time of death signed by the a 5 Other (specify) ☐Yes 2 2No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been si 1 ☐ Yes 2 ☐ No DEMENTIA Completed 24a. Was an page 2 s autopsy performed? certificate 2 No 1 ☐ Yes director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSIST. LIVUL Hospital: ၉ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, within 24 hours after death To the Funeral Director: / completely filled in by the f To the Hospital

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D01786 JULY 02 2004 allaper, MD dollvence 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maiden Choice have pacro Medisol aurence Gallages 31. Date filed (Month, Day, Year) 32. Registrar's Sanature JUL 0 6 2004

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Albert Armstrong Preston June 30, 2004 0450 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral X**2XM 2□ F Director 184-22-1885 June 30, 1927 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "naturel", or itema 23a or 28a-f ehov traumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Harford Maryland Forest Hill 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 910 Yvette Drive 21050 USA deeth 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: ↓ 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: 3 Widowed 4 Divorced WII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Chemical Engineer 4 U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 Is marked othany injury or other traumetic event Be Albert Ferguson Preston Miriam (nmn) Armstrong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Preston / Wife 910 Yvette Drive, Forest Hill, Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 2 Cra 1 D Buria 3 Removal from State Other (Spec \* 4 □ D6 Hilltop Service Corp. 7-1-04 Towson, Maryland Service Li 21. Sign <sup>22, Name and Address of Facility</sup>
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Pali 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 6 oscalte /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed burial-transit attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 SYes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 25 No 1 ☐ Yes reston Albert Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 3□ DOA Certification; To 1 Inpatient 2 ER/Outpatient 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury death. Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D18487

Registrar

MYO

THANT

#308922

602 S. Atwood 2. Registrar's Signature

21014

MD

BEL AIR,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward Buckley Rich Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-04302 Unpend Item #23a-b & 27 per ine C833 1-7/20704 las Mental Hygiene Certificate of Death Reg. No. DOS 1 - For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician July 2004 1039 a /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Northwest Hospital Center Randallstown Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (Ip yrs. last birthday) **Funeral** Months Days Hours Min 48-62-5696 1 M 2 □ F Yrs **Director** Usual Residence of Decedent with the Maryland 10d. Inside Øity Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Tres 2 □ No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or itams 23¢ or 2122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: BIACK þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Decements and Occupation

(Give kind of work done during most of working life. DO NOT use retired)

ROOFER permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If itam 27 is marked other than "ns any figury or other traumatic event, The Medis once. ROOFING + College (1-4or 5) ntary/Secondary (0-12) OUFER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Durns 20b. Place of Disposition (Name of Date 20c. Locati n - City or Town, State 20a. Method of Disposition emetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Greene Funeral 22. Name and Address of Facility town MD 21135 23a. Part1. Enter the direase, or complications that caused the death. Do not enter the mode of dying, such is cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrhythmia /Medical Due to (or as a consequence of) **Examiner** Hypertensive Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit the death certificate be executed Due to (or as a consequence of): Physician/Medical as the L phys esn IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 3 Probably 4 Unknown page 2 should Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 □ No certificate 2 No Vital Physician: Be director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 3**∑** DOA P Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) of 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending Division 1 X Natural 5 Pending within 24 hours after death.

To the Funaral Diractor: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier edical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number OCME July 2, 2004 of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 person who 30. Name and address U 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 6 2004 Registrar

Please	Type or Print in Black it	ndelible ink. Ens	sure All	Copies A	Are Legib
	Otata of Mandand / Dan		and the second		

	04-0426 RPD	4	1 - For State Registrar		f Marylar		artment of F			Reg. No	4 2	1084	
	Physici	an	Decedent's Name (First, Middle     Herman Rainey	, Last)					2. Date of Dea	Day \	Year	3. Time of beath	
	/Medic		al							0, 2004 4c. County of	Death	12:40 A <sup>M</sup>	
	LAGITIII	University Hospital Baltimore											
	Funeral Director		5. Social Security Number 218-44-8774 Usual Residence of Decedent	6. Sex 1 AM 2 ☐ F	7. Age ( <i>In yrs</i> . 57	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			9. Birthplac Country rylan	e (State or Foreign ) ad	
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d.	Inside City Limits	
	e Mar	ctor	Maryland		В	altimo:	re					1 X Yes 2 □ No	
	with th	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country	?	
	eath v	Funeral	1306 Pennsylva	12 Was Dec	edent Ever in U	. 7B	21217	ispanio Origina (		U.S.A.	- American	Indian	
920	172 hours after death with the Maryland "naturel", or Items 23s or 28e-1 show digst Examinar must be neithed at		1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed Fo	rceş? 2 ( <b>X</b> No ∕e		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	Specify:	rto Rican, etc.)	Black,	White, etc		
5-0	72 ho	eted	15. Decedent (Specify only highes	's Education it grade completed)		16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wo	orking	16b. Kind of Busi	ness/Indus	try	
Maryland 21215-0036	J withir jene. r then	Completed by	Elementary/Secondary (0-12)	1 _	DO NOT use retired pairman	()		Televis	ion				
nd	be filed ital Hygie d other event, it	Bec	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame)			
yla	should be and Mental a marked o	7	Arthur Lee Kell					Carrie					
Mar	2 s a a a a a a a a a a a a a a a a a a		19a. Informant's Name/Relations				ng Address (Street a			243000.00		,	
ď.	ages 1 and 3 and 3 and 3 and 4 and 4 and 4 and 4 and 5 and 5 and 6		Minnie O. Pitts  20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (S)	3 □Removal from			Gervine I sition (Name of natory or other plac Cemetery	9) 07/0	102, Ra 6/2004	20c. Location - Ci	ity or Town	Maryland State	
Baltir	permit. Pages 1 Department of H Importent: If Ite any injury or ot		21. Signature of Funeral Service	-		22	Name and Addres	s of FaciliThe	Derrick	C. Jones	F/H	P.A.	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximation of the disease of the death of the d										
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	-a. 5ta		ndof	the abdi				0.	nset and Death	
		Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	(or às à conseq	uence or).					-	- V	
8760,	ate be executed physician and the burial-transit	d											
O. Box 6	death certific e attending p id for use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	come of pregna pirth 2 ☐ Feta pant at time of d	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	e of delivery nth Day Year		
ords, P.	w requires that the been signed by th should be detache	by P	Part II. Other significant condition	ns contributing to d	eath but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribu		ause of death?	
Vital Records,	The law ate has b page 2 sl	Completed							24a. Was a autop perfor 1XYes	sy prid med? dea	or to comple uth?	findings available etion of cause of	
		o Be	25. Was case referred to medical examiner?  1X Yes 2 □ No	Hospital:		EB/Outration	Othe	20	ath (Check only or				
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ion		atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investig	ation 3/3	704	6:22		res 2 XNo	Subjec	t stahh	ec		
Division	or At fter of Direct in by	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 286. Mace	of Injury - At hong, etc. (Specify	ome, farm, str	eet, factory, office		_ City or Town	treet and Number n, State) NSYIVANI		oute Number, Baltineare	
	To the Hospitel or Al within 24 hours after or To the Funerel Directompletely filled in by	edical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the Examiner: On the b and man	best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and place pinion, death occi	e, and due to the curred at the time, d	ause(s) and mann ate and place, and	er as stated due to the	t. cause(s)	
	To the To the Comp	Ž	29b. Signature and title of certifier	. /			29c. License	number	2	9d. Date signed (/	Month, Day	, Year)	
	$\cap$		Lasha 3	Theers	es me		0.C.	M.E.		June 30,	2004		
	1			ineenber.	3 M.D.	1	Print)  11 Penn S	Street,	Baltimore	e, Maryla	ind 21	.201	
	Sta Registr												

		For State Registrar	State of Maryla	•	rtment of Health a	, ,	iene	21005		
Physic /Med Exam	lical	1. Decedent's Name (First, Middle, Las Gabriel 4a. Facility Name (If not institution, give Baltimore)	Pileta	Roo	riguez  4b. City, Torn, or Location of  Balti	2. Date of Deat	100	1 443 PM		
Funera Directo		5. Social Security Number 6. S	ex 7. Age (In yrs	80 Yrs.	If Under 1 Year If Under 2 Months Days Hours		, Year) 9. E	irthplace (State or Foreign Country) uba		
d 21215-0036 (27215-0036) (27215-0036) (1804 within 72 hours after death with the Maryland Hygiene.  When then "natural", or Items 23a or 28a-1 show ant, Ite Madical Examilian and the Madical Examilian and the matter in tilliand at	ctor	10a. State 10b. County MD. N/A		ity, Town or Lo				10d. Inside City Limits  1₩ es 2 □ No		
with the	Dire	10e. Street and Number 1431 Bonsal Stree	+		10f. Zip Code 21 224	1	0g. Citizen of What out of What out of What out of What out of the What out of	Country?		
36 rs after death with the Marylan r, or Items 23a or 28a-1 show	/ Funerai Director	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ever in I Armed Forces? 1 XYes 2 No If Yes, Give	- 11	Vas Decedent of Hispanic Origing Yes, specify Cuban, Mexican,  X Yes 2□ No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc. Iispanic		
21215-0036 of within 72 hours af giene. er then "natural", or the Medical Exam.	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ec  (Specify only highest gra	Year or Dates: lucation de completed)	16a. Deced	ent's Usual Occupation kind of work done during most of NOT use retired)		16b. Kind of Busines			
d 212 filed with Hygiene. other ther ent, it e.v.	mo.	Elementary/Secondary (0-12)  8 years	College (1-4or 5+)	Merc	hant Marine		Maritime			
Vlan	To Be C	17. Father's Name (First, Middle, Last) Pedro Rodriguez			18. Mother	s Name (First, Middle, I rina Pileta				
		19a. Informant's Name/Relationship ( Connie Rodriguez	wife	1431	g Address (Street and Number Bonsal Street,	Baltimore,				
S 5 5 2 2		20a. Method of Disposition  1  → Burial 2 □ Cremation 3 □  → 4 □ Donation 5 □ Other (Specify			ry Cemetery J	Date [uly 6,2004]	20c. Location - City of Dundalk			
Baltime permit, Pag Department Importent: I any injury o		21. Signature of Funeral Service Licer	Connell	1	Name and Address of Facility Onnelly Funera 110 Sollers Po	HITE KOAO I	ningalk Mo	A. . 21222		
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/Medica Examine		resulting in death)	Due to (or as a conse		HEAR! I'A			MONTHS		
suted of ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
ox 68760, certificate be executed iding physician and use as the burial-transit	dicai Ex	resulting in death) Last								
o.O. Box 68  In the death certific  by the attending place as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)		23d. Date of d Month	elivery Day Year		
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ston sath. or: Afte	atio	1 Natural 5 Pending 2 Accident investigation		Injury	Work? M 1 ☐ Yes 2 ☐ No	0				
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Division of Vital with the Hospitel or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the tuneral director.	edical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my kn niner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the time, date and estigation, in my opinion, death	place, and due to the ca occurred at the time, da	ause(s) and manner ate and place, and de	as stated. ue to the cause(s)		
To t To t	Σ	29b. Signature and title of certifier	21		29c. License number		9d. Date signed (Moi			
/	15	30. Name and address of person who	completed cause of death (Ite	am 23a) (Ta f	P16468	VAMC	7-01-	99		
2		-tr ()			St, Balt		1D 212	$\circ$		
	35.0	Thomas Fearse	10 10.	THE WENT	- 31, Odil	1				

			For 1 State	State of Marylan	•			Mental Hy		001	01006
			Registrar		Cel	tificate of	Death	O Data of D	Reg. No.	004	21086
	Physici	an	Decedent's Name (First, Middle, Last,	)				2. Date of D Month	Day	Year	3. Time of Death
	/Medic		Craig O. Reed					July	4,	5004	3.33 P
7	Examin	er	4a. Fecility Name (If not institution, give		1	0 :	or Location of Dea	th		County of Deeth	
			5. Social Security Number 6. Sec		iter	If Under 1 Year	If Under 24 Hrs	8. Date of B		altin	nplace (State or Foreign
	Funeral		118	x 7. Age (#7)/s. /	Yrs.	Months Days	Hours Min	. (Month, D	ay, Year)	Col	intry)
	Director		169-40-4508 Usual Residence of Decedent				<u> </u>	Oct. 1	,194	о га.	•
	/land		10a. State 10b. County	1	, Town or Lo						10d. Inside City Limits
	Many Fresh	tor	Md. Baltimo	ore	Dundal	k					1 ☐ Yes 2 No
	r 288	Director	10e. Street and Number			10f. Zip Code			10g. Citia	zen of What Cou	intry?
	h with		1614 Four Georges	ct.		21222			U	SA	
	deat	by Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (	Specify Yes or N	0-	14. Race - Amer Black, White	
ဖွ	or Ite	/Fu	1 Never Married 2 X Married	1 ☐ Yes 2 ŽNo II Yes, Give		1 □ Yes 2 No	Specify:	10 7 110 1111 11 1111		_	ite
8	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28a-f show your. The Medical Examination must be retified at	d b	3 Widowed 4 Divorced	Year or Dates:							
5	72 h	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup kind of work done	during most of wo	orking	16b. Kir	nd of Business/l	ndustry
2	han han	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	a)		D	isabled	
, 7	lled v Hygie ther t	ပိ	7 yrs. 17. Father's Name (First, Middle, Last)		L	isabled	18. Mother's Na	me (First, Middle			
and	od of	Be	Harold Reed				Coleda			our anno,	
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event. It a Medical Exact in a marker rolling at	2	19a. Informant's Name/Relationship (T)	voe Print)	19h Mailir	ng Address (Street			-	Town State 7	in Code)
Ma	d 2 s, th an 7 ls i		Mildred Reed	wife	1.	4 Four G			-		
ė,	of Health aritem 27 is		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of		Date	_	cation - City or 1	
Baltimore,	nt of nt of t: If it		1 X Burial 2 ☐ Cremation 3 ☐ F	removal from State   Car	emetery, crei cdens (	natory or other pla Of Faith	∞) Ju] Cem. Ju]	y 9 2004	Ros	sville	
턡	it. Partmentani		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licens</li> </ul>	<u> </u>							
Ba	permit. Pages 1 and Department of Heall Important: If item 2 any injury or other 2006.		Va thous	Consolly		Name and Addre Onnelly 1110 Soll	Funeral	Home Of	Dunda 21222	alk	
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			shock, or heart failure. Ust only o Immediate Cause (Final	ne cause on each line.							Interval Between Onset and Death
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	Examiner			metacta	+ 10	DIALL	cal e	ffusi	nn		
	ALC: N	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq	uence ur).	Piccu		1 1 (452)			
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	COSTFIC	DI.	mary	Chry	15			
Ć,	exector and and rial-tr	Exa	resulting in death) Last	D to (or as a conseq							
8760,	cate be executed physician and the burial-transit	dical		d							
9	tifical g ph as th	ledi									
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	D 0 0	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d		Other (specify)	,			Month	Day Year
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s, D	law requires that the as been signed by th 2 should be detache	by F	Part II. Other significent conditions co	ntributing to death but not res	ulting in the u	nderlying cause gr	ven in Part I.				the cause of death?
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000	has be	pie						24a. Wa	s an opsy	24b. Were aut	topsy findings available ompletion of cause of
Ä	9 4 9	Completed						per 1 ☐ Yes	ormed?	death? 1 ☐ Yes	
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f V	Ø .≤ ₽	To I	1 ☐ Yes 2 No	Hospital: 1 Impatient 2	ER/Outpatier	nt 3□ DOA Ott	her: 4 ☐ Nursing	Home 5 ☐ Res	idence 6	Other (Spec	ify)
n of			27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju Wo		28d. Describe	how injury	occurred	
Ö	Attending r death. ector: After by the fune	atic	2 Accident investigation			M 1	Yes 2□No				
Division	or Attendate death Director:	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	reet, factory, office			(Street and own, State)		ral Route Number,
	ital or irs afte ral Dir led in	O						<u> </u>			
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina	wledge, deat tion and/or in	h occurred at the ti vestigation, in my o	ime, date and plac opinion, death occ	e, and due to the curred at the time	e cause(s) , date and	and manner as place, and due	stated. to the cause(s)
	the the	Med	29b. Signature and title of certifier	and manner stated.		29c Licens	se number	1	29d Date	e signed (Month	Day Year)
	To with		250. Signature and title of certifier			Dar				2 3.g 02 (month)	20,011
	4		130 My-			Kes	2000	)	Ju	144,	9004
	(		30. Name and address person who c	ompleted cause of death (Item	1 23a) (Type.	Print)	om T	D 1		ma 1 1 1	D 2173=
	4 4		Jeffrey Swet	32. Registrar' Sinna	ture /	in Jau	ure Dry	ic bal	rimo	IE, M	7 CP1P A
	Sta Regist		JUL 0 6 2004 /	ompleted cause of death (Item  MD 9000 F  32 Registrary Signa	good	Ker !					

		For AMEND ITEM 17 Registrar  1. Decedent's Name (First, Middle, Last)							2004 ay Yeer	2   0 8 7 3. Time of Death	_
Physicia /Medic		IDA		R	FUVE	NI	2. Date Month	LY	1 200	1407:34 AM	_
Examin		4a. Facility Name (If not institution, give,	street and number)	1	4b. City, Town	, or Location of	of Death	4	c. County of De	ath	
(a)		the Johns Hop	OKINS HOS	ptial	If Under 1 Ye	ar If Under	24 Hrs. 8. Date	O Birth	N/A	irthplace (State or Foreign	_
Funeral Director		5. Social Security Number 6. 96. 96. 96. 96. 96. 96. 96. 96. 96.	х ] м 2 Q F	vrs. last birthday, 93 Yrs.	Months Day		Adia /Adopt	5/191	6	POLAND	
ס		Usual Residence of Decedent									_
arylan show	_	10a. State 10b. County		City, Town or L	ocation					10d. Inside City Limits 1 ☐ Yes 2 No	
the M	Director	N.J. MERCER	EV	WING	10f. Zip Code			10a C	itizen of What (		_
with Mith	i Dir	53 WALTER STREET			08628				.S.A.		
death	Funerai		12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of	of Hispanic Ori	gin? (Specify Yes , Puerto Rican, etc	or No-	14. Race - An Black, Wh		_
or ite	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 Mo If Yes, Give		1 Yes 2 X		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	/	Specify: W		
hours tural'	ed b	3 ₩Widowed 4 □ Divorced  15. Decedent's Edu	Year or Dates:	16a. Dece	ident's Usual Oc	cupation		16b.	Kind of Busines		_
od within 72 hours after death with the Maryland gjene. gjene. er then "naturel", or Items 23a or 28a-f show , the Medical Ezar if et intal be indiffed at	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work do DO NOT use ret	ne during mosi ired)	t of working				
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lid be filt fental Hy rked oth	Be	17 Father's Name (First, Middle, Last) LETB AVIGDOR RUTK	0701717				er's Name <i>(First, M</i>	liddle, Maide		TAINABLE	
nd 2 should be file thand Mental Hy 27 is marked oth traumatic event	٩	19a. Informant's Name/Relationship (Ty		19b. Mail	ino Address (Stre	TZIPF	er or Rural Route N	lumber, City			_
		LIVIA MEZRICH/DAUG					EAST WIND				
of Health Item 27		20a. Method of Disposition	20	b. Place of Disp			Date	20c.	Location - City	or Town, State	
nit. Pages partment of it cortent: if its injury or or		1  Burial 2  Cremation 3  F  1  Other (Specify)	demoval from State BI	ETH"ISRA	PARK	KIAL 07	7/02/2004	W00	DBRIDGE	, N.J.	
permit. Pages 1 al Department of Hea Importent: if Item any injury or othe		21. Signature of Funeral Service Licens	00		2. Name and Ad		OUL LEV		& BROS	THE RESERVE OF THE PARTY OF THE	
20200		23a. Part1. Enter the disease, or compl	lications that caused the r						ESVILLE	MD_21208	Ť
		shock, or heart failure. List only or	ne cause on each line.					ory arrest,		Onset and Death	en
Physician /Medical		disease or condition resulting in death)	a. ASPIRA Due to (or as a con		FNE	UMON	////			5 HOUR	ŀ
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po #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con								
be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a con	sequence of):							
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eath certific attending p	an/N	23b. was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	Fetal death 3	⊒Ectopic pr <b>eg</b> na				23d. Date of d	elivery Day Year	
at the dea by the at	ysici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify)	)			11.01.111		
' E 2 B		Part II. Other significant conditions con	intributing to death but not	resulting in the	underlying cause	given in Part I	. 23e.	Did tobacco	use contribute	to the cause of death?	
he law requires t e has been signe sge 2 should be o	ed by							1 🗌 Yes	2 No 3 🗆	Probably 4 DUnknown	
aw requir s been si 2 should l	Completed						24a.	Was an autopsy	24b. Were	autopsy findings available completion of cause of	_
The law cate has page 2 s	Com						10	performed?	death'	?	
sicien: Th certificate lirector, pag	Be (	25. Was case referred to medical examiner?	Uaaaitat.				of Death (Check	only one)			
Physi r this c	. To	1 ☐ Yes 2 No	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatie	III OLI DOA		ursing Home 5   28d Des		6 □Other (Sp	pecify)	
Jing After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	ir) Injury		njury at Work? I □ Yes 2 □	,		, and a second		
	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, s	treet, factory, offi	ce		tion (Street or Town, Sta		Rural Route Number,	i
Atten r deat ector: by the	-	4 D Homicide	building, etc. (3)	iecny)			Cny	or 10411, Old			
lal or Attending 's after death. al Director: Afte ed in by the fune	Cel		sician: To the best of my	knowledge, dea nination and/or i	th occurred at the	e time, date an ny opinion, dea	nd place, and due to	o the cause time, date a	(s) and manner and place, and d	as stated. ue to the cause(s)	
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the Hospital or Attenthin 24 hours after death the Funeral Directors mpletely filled in by the		(Check only 2 Medical Exami	iner: On the basis of exam and manner stated.		29c. Lic	ense number		29d. F	Date signed (Mo	nth, Day, Year)	
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		_	- For AMEND ITEM 19A PER FH,	uyland / Dep G833,07/06	artment of He /04DHB rtificate of D	ealth and M Death	ental Hygie	ene . No. 2 0 0 4	21088
	Physici	an	Decedent's Name (First, Middle, Last)  DAN		RANDOLPH		2. Date of Death	Day Year 2004	3. Time of Death 2:40 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	Location of Death		4c. County of Death	
			LORIEN REHAB CENTER  5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday	) If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	9 Rirth	HOWARD place (State or Foreign
	Funeral Director		112-32-6321 <sup>1</sup> X <sup>2□</sup> F	92 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, You DEC. 10, 1	911 CZE	CHOSLOVAKIA
	land ow	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	e Mary la-f sh	ctor	MD HOWARD	ELKF	RIDGE				1 ☐ Yes 2 No
	with th	Director	10e. Street and Number		10f. Zip Code	21075	10g	. Cîtîzen of What Cou	untry?
	ms 23	Funeral	6391 ROWANBERRY DRIVE  11. Marital Status  12. Was Decedent E	Ever in U.S. 13.	Was Decedent of His	spanic Origin? (Spe	cify Yes or No-	14. Race - Amer	ican Indian,
36	72 hours after death with the Maryland Inaturel', or Items 23a or 28a-f show UEal Examination out the motified at	by Fur	Amed Forces?  1 □ Never Married 2 ☒ Married 1 □ Yes, 2 ☒ N  3 □ Widowed 4 □ Divorced Year or Dates:	lo	If Yes, specify Cubar  1 ☐ Yes 2 ☑ No	Specify:	Hican, etc.)	Black, White	WHITE
2-00	"naturel",		15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupa s kind of work done do	uring most of workii	ng 16	b. Kind of Business/Ir	ndustry
21215-0036	within ene. than	Completed	Elementary/Secondary (0·12) 2 College (1-4or 5	/life.	DO NOT use retired) NUSICIAN			MUSIC	
and	should be filed and Mental Hygin marked other matic event, I	Be	17. Father's Name (First, Middle, Last)  ALFRED	ΙΑΝΓ	DERER	18. Mother's Name		iden Sumame) JNKNOWN	
Maryland	2 should be and Mental is marked of reumatic ev	<u>م</u>	Gariatermant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street a	nd Number or Rura	l Route Number, C	City or Town, State, Zi	
	of Health item 27 other tr		GERTRUDE RANDOLPH / WIFE  20a. Method of Disposition	20b. Place of Disp	osition (Name of	! D		GE, MD 210 c. Location - City or T	
mol	0 0		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)		SERVICE C		2004	TOWSON,	MD
Baltimore,	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Licensee					N & BROS., KESVILLE,	
п			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not er				_	Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	monia					Onset and Death  2 weeks
	/Medical Examiner	П	Due to (or as:	a consequence of):					
3	be is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cauce (Disease or injury	a consequence of):					
oʻ	cate be executed physician and the burial-transit	Examiner	that initiated events c.	a consequence of):					
68760,	tificate being physicias the bu	edical	d						
. Box	attendir for use	Physician/Me	1 Yes 2 No	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliver Month	very Day Year
s, P.O	res that the disigned by the be detached	by Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death be	ut not resulting in the		n in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ords	w requires been sign should be	ted b	Congestive heart Aprelic Stenosis	Failur	٧.		1 ☐ Yes	2 No 3 □ Pro	bably 4 Unknown
of Vital Record	The law re te has be bage 2 sh	Completed	Aertic Stenosis	\$			24a. Was an autopsy performe	24b. Were aut prior to co death?	opsy findings available ompletion of cause of
/ital	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner?		04-	26. Place of Death			
	Physi r this o	1: To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatie  27. Manner of Death 28a. Date of Injur	ry 28b, Time	of 28c. Injury	at Nursing nor	me 5 Residence 28d. Describe how	ce 6 □Other (Specinjury occurred	ify)
ion	ttending I death. stor: After t the funer	atlor	1 X Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	Y Year) Injury	Work	? ′es 2 □ No			
Division	for Attendater death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
_	Hospite 24 hours Funeral	edical C	29a. Certifier (Check only one)  Certifying Physicien: To the best of and manner starting and manner start	examination and/or i	ath occurred at the tim nvestigation, in my op	e, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	To the within 7 To the comple	Me	29b. Signature and title of certifier	m.D.	29c. License			. Date signed (Month	
	,		30. Name and address of person who completed cause of d	eath (Item 23a) (Type	a, Print)	0271		, w-vy 04	210/11
	4	4.	Harry Li, 10790 Hi  31. Date filed (Magnin Day, Year)  32. Registra	ckory R ar's Signature	idge Ro	pad, co	lumbia,	Tuly 04 mD.	21044
:	Sta Regist	ate rar	31. Date filed (Moant, Day, Year) 32. Hegistri	we b	low	4			

_		1 - Stata AMEND ITEM 19 Registrar  1. Decedent's Name (First, Middle, Last		Cei	tificate	of D	eath	2. Date of D	Rag. No.	104	2   0 0 0
Physic /Medi		MILDRED		R	060	FF	:	Month	Day	Year 2004	9:01 0
Exami		4a. Facility Name (If not institution, give NORTH WEST HOS	street and number)		(ZAND	ALLS	ocation of De TOWへ	7	BA	ounty of Death	
Funeral Director		5. Social Security Number 6. Se 215-05-8973  Usual Residence of Decedent	7. Ag	e (In yrs. last birthday)  104 Yrs.			If Under 24 H Hours Mi	n (Month D	irth Day, Year) 1,190(	9. Birthp Cour	POLAND
e Maryland ta-f show lifted at	ctor	10a. State 10b. County  MD BALTIN	10RE	10c. City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🎖 No	
with th	i Director	10e. Street and Number 601 SUDBROOK LANE	=		10f. Zip C		21208		10g. Citizer	of What Cour	ntry? J.S.A.
2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. Is marked other then "neturel", or Items 23a or 28a-f show eumetic event. Ite Medical Eracinstructuration inclined at	d by Funerai	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 X If Yes, Give Year or Dates:	No	Was Deceder of Yes, specify	nt of Hisp Cuban,		(Specify Yes or N erto Rican, etc.)		Race - Americ Black, White,	can Indian,
s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene. item 27 is marked other then "netur other treumetic event, the Medical	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed) College (1-4or	(Give	dent's Usual 6 kind of work DO NOT use	done dui retired)	on ring most of w	vorking		of Business/In	,
id 2 should be file th and Mental Hyg 27 Is marked othe treumetic event,	To Be C	17. Father's Name (First, Middle, Last) HARRY		W	\SE	1	8. Mother's N	lame <i>(First, Middl</i> E	e, Maiden Su		(NOWN)
nd 2 sho Ith and h 27 is ma		19a. Informant's Name/Relationship (T) GORDON WASE / - COI	урө, Print) <mark>JSIN NEP</mark> H					Rural Route Num. 10 - PHI			
permit. Pages 1 and 2. Department of Health at Importent: if item 27 is any injury or other tree.		20a. Method of Disposition  1 💢 Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from State	20b. Place of Dispo	sition (Name natory or othe	of er place)		Date 5/2004	20c. Locat	SEDALE	own, State
permit. Departn Importe any inju		21. Signature of Funeral Service Licens	Runl	22	. Name and	Address	of Facility S	OL LEVIN ROAD -	SON &	BROS.,	INC.
certificate be executed / Medical Examiner   Medica	dicai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last				Approximate Interval Between Onset and Death					
n certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mophs? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	Ectopic preg Other (spec				23d	I. Date of delive	ery Day Year
hat I od by deta	b	Part II. Other significant conditions co	ntributing to death b	out not resulting in the u	nderlying cau	se given	in Part I.		tobacco use	/	ne cause of death?
The law ate has b page 2 st	Completed							24a. Wa auto peri 1 🗆 Yes	s an 2 opsy formed? 2 No	14b. Were auto prior to co death? 1 \( \text{Yes}	psy findings availab mpletion of cause of 2 No
ng Phys fter this	ation; To Be	27. Manner Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Hopatii 28a. Date of Inju (Month, Da			Other: Injury a Work?	4 🗆 Nursing	Home 5 Res 28d. Describe	sidence 6	- ' '	y)
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In building, et	jury - At home, farm, str c. (Specify)	eet, factory, o	office		28f. Location City or To	(Street and Nown, State)	lumber or Rura	l Route Number,
ne Hospi 124 hour ne Funer iletely fill	edicai	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exami	sician: To the best ner: On the basis of and manner st	of my knowledge, death of examination and/or in ated.	n occurred at vestigation, in	the time, my opin	, date and pla nion, death oc	ce, and due to the curred at the time	e cause(s) and , date and pla	d manner as si ace, and due to	tated. the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier				icense r			29d. Date s	igned (Month,	Day, Year)
5		30. Name and address of person who co		A A I	Print)		722		JULY	4 2	<del>2004</del>
		31. Date filed (Month, Day, Year)	UN 540	1 OLP COUR	IT ROA	<b>P</b>	(2ANDF	ALL STOW!	U, MI	211	5 5

	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 1 1 2 1 1 0 0
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)  GERALD M.  ROSENTHAL  2. Date of Death Month JULY 3, 2004  12:20 PM  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
Funeral Director	HOSPICE OF BALTIMORE GILCHRIST CENTER  5. Social Security Number 220-22-9094  TOWSON  TOWSON  BALTIMORE  F. Age (In yrs. last birthday) Towns Days  Towns Days  Hours Min. (Month, Day, Year) OCT.19,1927  MD  BALTIMORE  9. Birthplace (State or Foreign OCT.19,1927) MD
e Maryland la-f show lifted at	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits           MD         BALTIMORE         BALTIMORE         1 □ Yes 2 □ No
636 036  ours after death with the Marylan elf. or items 23e or 28e-f show Essuchment be rudified at by Funeral Director	10e. Street and Number 42 STIRRUP COURT  10f. Zip Code 10g. Citizen of What Country?  10g. Citizen of What Country?  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
d 21215-0036 d 21215-0036 lifed within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene. Hygiene star must be notified at ont, the Medical Every art must be notified at a Completed by Funeral Director	1 Never Married 200 Married   1.00 Yes 2 No NATY   1 Yes 200 No Specify:   Specify:   WHITE    15. Decedent's Education   16a. Decedent's Usual Occupation   16b. Kind of Business/Industry
Ind 21215-0 be filed within 72 ho tal Hygiene. d other than "nature ovent, it is Medical.  Be Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  5+  College (1-4or 5+)  ADMINISTRATOR  DEPT. OF LABOR  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)
laryla 2 should and Merkee eumatic To	HERMAN  ROSENTHAL  RAE  GOODMAN  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
orfe, ss 1 ar st Head item.	MAXINE ROSENTHAL / WIFE  42 STIRRUP COURT - BALTIMORE, MD 21208  20a. Method of Disposition  1 \( \text{\text{M} Burial} \) 2 \( \text{\text{Cremation}} \) 3 \( \text{\text{Removal from State}} \)  42 STIRRUP COURT - BALTIMORE, MD 21208  20b. Place of Disposition (Name of cametery, crematory or other place)  43 Burial 2 \( \text{\text{Cremation}} \) 3 \( \text{\text{Removal from State}} \)  44 Donation 5 \( \text{\text{\text{Color}}} \) Other (Specify)  45 Donation 5 \( \text{\text{\text{Color}}} \) Other (Specify)  47 Donation 5 \( \text{\text{\text{Color}}} \) Other (Specify)
Baltimo	14 Donation 5 Other (Specify) HEBREW YOUNG MEN CEM 7/5/2004 WOODLAWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTUWN ROAD - PIKESVILLE, MD 21208
Physician /Medical	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a
7Cr & Co, 150, 150, 150, 150, 150, 150, 150, 150	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit completed by Physician/Medical Examit	IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery
P.O. Bc that the death ad by the atter detached for the Physician	230. Was december pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  1  Vive birth 2 Fetal death 3 Ectopic pregnancy  5 Other (specify) Month Day Year
Records, P.O. Ender the dea Records, P.O. Ender the dea the signed by the at 1992 2 should be detached to mapleted by Physicial	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
	24a. Was an autopsy findings available prior to completion of cause of death?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)
Phy Phy	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DoA Other: 4 Nursing Home 5 Residence 6 Rother (Specify) Spice  27. Manner of Death 1 North Natural 5 Pending investigation   28a. Date of Injury (Month, Day Year)   28b. Time of Injury Month, Day Year   28b. Time of Injury Month, Day Year   28c. Injury at Work? 1 Yes 2 No   28d. Describe how injury occurred   28d. Describe how injury oc
Division or attending urs after death or attending lead in by the tune lived in by the tune Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Div To the Hospital or A within 24 hours after completely filled in b, Medical Certif	29a. Certifier (Check only one)  1
F S F 5	MANThrysling. und DD5205 July 3, 2007  30. Name and address of person who impleted can be of death (Item 23a) (Type, Print)
State Registrar	1). A. Riley G. Bon (6701 N. Charles S). Bolts. and 2120x  31. Date filed (Month, Day, Year)  32. Degistrar's Signature & Spark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2004 **Physician**  $J_{uly}^{MORIN}$  3, Christine Elizabeth Reynolds 6:30 ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Health Of Catonsville Catonsville Baltimore CATORSVILLE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | March | 11,1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ■ M 2 B/F 78 Director 227-22-4127 Virginia Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4220 Hamilton Avenue 21206 U.S.A. or Items 23a Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 Divorced White natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed within Health and Mental Hygiene. Item 27 is marked other than Nurse's Aide Hospital 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Shannon Lowe Maggie Nunn ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4220 Hamilton Avenue, Baltimore, Maryland 21206 Clayton Reynolds (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages 1 Department of H Important: If ite t X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gar. July 6,2004 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility P.A. Bruzdzinski Funeral Home, P.A. 21 al mature of Funeral Services in insee 1407 Old Eastern Avenue, Essex, Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease sondition resulting in death) Physician ementra /Medical Due to (or as a consequence of): Examiner sphapa Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events Due to ir a la consequence of): Examiner death certificate be executed the attending physician and hed for use as the burial-transIt 5 (months VA resulting in death) Last Due to (or as a consequence of): Physician/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) o. detached 9 Unknown 9 Unknow signed by t ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 1 🗌 Yes 2 🗆 No 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performe Yes 2 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 ☐ Yes 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the h 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ratild 256520 on, ore

State Registrar

DHMH 17 Rev 1/2001

6701 N-Charles ST. Battimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GBMC

32. Registrar's Signature

50

MATILDA

31. Date filed (Mark Da

			1 - For State Registrar	State of Marylan		artment of H			giene	1 21002
	Dhunini		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physici /Medic		Donald	Steele	-			JULY	1 20	104 9:15 PM
	Examin	er	4a. Facility Name (If not institution, give s	DRIVE		4b. City, Town, or	Le Rive		4c. County of	Death Limore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 h	Irs. 8. Date of Birt		
	Director		212 30 37.3	IM 2□F 6	4 Yrs.	Months Days	Hours N	lin. (Month, Day	0.1940	9. Birthplace (State or Foreign Country) West Virginia
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	Mary -f sho	to	MD. Baltimore	e	Middl	e River				1 ☐ Yes 2X No
	ath with the Marylar 23e or 28e-f show	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	ath wi	ral	105 Dihedral Drive			212			USA	
920	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23e or 28e-f show event, I're Madical Exartiner: mat be rutified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2X No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2⁄Q(No	ispanic Origin? In, Mexican, Pt Specify:	' (Specify Yes or No- uerto Rican, etc.)	Black,	American Indian, White, etc. White
21215-0036	within 72 hours ene. than "natural; he Madical Exe	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of	working	16b. Kind of Busi	·
121	Hygier Hygier Ither ti		12 YRS.  17. Father's Name (First, Middle, Last)		M	anager	18 Mother's I	Name (First, Middle,	Box Fact	
and		To Be	Ralph Steele					a McCoy	maidon comano,	
Maryland	shound N	_	19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailir	ng Address (Street a	and Number or	Rural Route Numbe	r, City or Town, St	ate, Zip Code)
	s 1 and 2 of Health a item 27 ls other tra		Susan Zelechowski			Goosemar		ising Sun		
Baltimore,	Pages 1 nent of H ont: If ite ury or otl		20a. Method of Disposition 1	emoval nom State		sition (Name of matory or other place Cemetery		Date y 6,2004	20c. Location - Co	
Balt	1   Section   1   Section								Dundalk, Dundalk,	P.A. Md. 21222
			23a. Part1. Enter the disease, or compli shock, or heert failure. List only or	cations that caused the deat ne cause on each line.	h. Do not ent	er the mode of dyin	g, such as card	diac or respiratory are	rest,	Approximate Interval Between
H	Priysician		Immediate Cause (Final disease or condition resulting in death)	LUNG C	ANCER					Onset and Death  6 MONTHS
1.	/Medical Examiner		Toodining in again,	Due to (or as a conseq	uence of):					
	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause [Disease of injury	Due to (or as a conseq	uence of):					
	cate be executed obysicien and the burial-transit	Examine	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	sicier sicier e buri	cal		1						
9	rtifical ng phy s as th		IF FEMALE:			1.500				
O. Box	The law requires that the death certificate be executed to has been signed by the attending physicien and oage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	· ·
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lon	Attending F r death. ector: After by the funera	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 ☐ No			
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	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	(Check only 2   Medical Examile one)	ner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my op	pinion, death o	ccurred at the time, c	date and place, and	d due to the cause(s)
	To To	2	29b. Signature and title of certifier	nao		29c. License	o number 0028		JULY	Month, Dey, Year) 2 2004
,	$\circ$		30. Name and address of person who co		n 23a) (Type.	Print)				- 200
	A.		TARA UN, MD &		ROADU	DAY BAL	TIMOR	E, MD	21231	
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 0 6 2004	32. Registrar's Signa		ads				

State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND ITEM #20B PER FH G833 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ASA SHEPHERD JULY 2, 2004 0037 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL WESTMINSTER CARROLL HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 02-24-1955 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 216-66-8647 **X**(**X** M 2□ F Months Days Hours 49 MARYLAND Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. tnside City Limits or 28a-f show other traumatic event, the Medical Examinar Fluis Le Publified at MD. CARROLL HAMPSTEAD 1 ☐ Yes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4299 HUNTSMAN TRAIL 21074 U. S. A. Items 23g Be Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritat Status Btack, White, etc. 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 XIX Specify: If Yes, Give Year or Dates: WHITE 3 Widowed 4 Divorced 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GERBERS COMPANY TRUCK DRIVER 9 YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill I Health and Mental H tem 27 Is marked oth **JOSEPH** SHEPHERD EILEEN EMMA HOWARD 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 M. DONNA SHEPHERD (WIFE) 4299 HUNTSMAN TRAIL, HAMPSTEAD, MARYLAND, 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 7/06/04 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of H ant: If ite 1 ☐ Burial 2 🕅 cremation 3 ☐ Removal from State permit. Page Department c Importent: If eny injury or once. HILLTOP SERVICE CORPL <del>2004</del> TOWSON, MD. 21204 1 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 utt 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovascula Priysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 \sum No 24a. Was an page 2 autopsy performed? 1 Yes 2 No Vital Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No 2 ER/Outpatient 3 □ DOA Certification: To 1 Inpatient o 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Intury 1 Natural 2 🗌 No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 2 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E JULY 2, 2004 ed cause of death (Item 23a) (Type, Print) 30. Name and address of p 12, 111 Penn Street, Baltimore, Maryland 21201 t 32. Registrar's Signature 31. Date fited (Month, Day, Year) State Registrar JUL 0 6 2004

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Funeral		5. Social Security Number 6. Sex 7. Age (In ye	s. last birthday	) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. E	Birthplace (State or Foreign Country)	
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or 2	Director	10e. Street and Number		10f. Zip Code		100	. Citizen of What	Country?	
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er de Items	Funeral	11. Marital Status  12. Was Decedent Ever in Armed Forces?	10.5.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, W		
s aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🐧 No If Yes, Give 1 ☐ Yes 2 1 € 1 ☐ Yes 2 ☐ Yes		1□Yes 2XXVo	Specify:		Specify:	White	
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2 shou and he le mail	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street a	and Number or Run	al Route Number, (	City or Town, State	e, Zip Code)	
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Departing Permit Departing Permit Per		Haw litters an		1050 York	k Road	Towson,	Maryl	and 21204	
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Ψ		30. Name and address of person who completed cause of death (				^ لحجة البرة	1004		
	ate		<u>prK KOd∢</u> gnaty•re	d #102 To	wson, Ma)	ryiand 2	1204		
Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Si	D A	parks					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death July 3, **Physician EDWARD** G. SELLMAYER 2004 1:48 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, **Funeral** 213-30-9133 XXM 2DF 75 MARÝLAND Director 10-09-1928 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "naturel", or items 23e or 28e-f show treumatic event, the Madical Exeminer must be neithed at TIMONIUM MD. BALTIMORE 1 ☐ Yes 2XXVo Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 16 INVERIN CIRCLE U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1XX es 2 No OREAN If Yes, Give WAR 1 Never Married 2XXMarried 1 ☐ Yes 2XXNo Specify: WHITE Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BALTIMORE CITY Elementary/Secondary (0-12) College (1-4or 5+) YEARS Hygiene. ADMINISTRATOR DEPARTMENT EDUCATION TEACHER AND 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental I **EDWARD** J. SELLMAYER CATHERINE E. MILLER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARGARET A. SELLMAYER (WIFE) 16 INVERIN CIRCLE, TIMONIUM, MARYLAND, 21093 Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of P Importent: If ite any injury or ot once. XBurial 2 ☐ Cremation 3 ☐ Removal from State HOLY REDEEMER CEMETERY 07-08-2004 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYUCAVOLLAL Physician hours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sua to for as a consequence of Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE es n 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ dtion 1 Yes 2 No 3 Probably 4 Unknown Completed Ubpt 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy certificate 1 🗌 Yes Vital 2 No fo the Hospitel or Attanding Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dippatient P 2 ER/Outpatient 3 DOA this Division of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funerel ( 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00051347 Cynthra 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Baltimere SociaNo MO Cynthia 6701 32. Registrar's Signature 31. Date filed (Month, Day, Year) 0 6 2004 Registrar

DHMH 17 Rev 1/2001

jell mayer

			For State Registrar	State of M	1aryland		rtment of H		ind Mei		giene 1eg. Np? () (	71.	21000
	Physici		1. Decedent's Name (First, Middle, Last Doris Schlissler	)						Date of Dea Month June	ith Day	Year 004	3. Time of Death 6:00 p <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give Greater Baltimore	Medical	Cente		4b. City, Town, or Towson		f Death		4c. County Balti	of Death	
	Funeral Director		5. Social Security Number  212-20-6727  Usual Residence of Decedent	x 7. A	78	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8.	Date of Birth Month, Pay 1/22/1	926	9. Birthp Coun Mar	lace (State or Foreign try) yland
	e Maryland Ba-f show diffed at	ctor	10a. State 10b. County MD N/A			Town or Lo	e						0d. Inside City Limits 1X Yes 2 ☐ No
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Maryland 21215-0036	within 72 hou lene. 'than "natura Ire Medical E	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		r 5+)	(Give life. L	ent's Usual Occupa kind of work done o OO NOT use retired endant	turina most	of working		16b. Kind of Business/Industry  Bus Company		
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8760,	death certificate be executed  Wedical  Be attending physician and  of for use as the burial-transit	dical Examiner	23a. Part 1. Enter the disease of same shock, or heart failure. List only disease or condition resulting in death)  Esquartially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	is a consequence	ence of):	Em	Car.	lurt	a -		-	Interval Between Onset and Death
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Division of Vital Records,	To the Hospital or Attending Physicien: Th within 24 hours after death.  To the Funere! Director: After this certificate completely tilled in by the tuneral director, pag	tion; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Man of Death  1  Natural 5 Pending investigation	Hospital: 1 par 28a. Date of In (Month, D		ER/Outpatien 28b. Time of Injury	28c, Injury Work	er: 4 □ Nur	sing Home 28d		ence 6 Otho		)
Divisi	al or Attending s after death. it Director: After ed in by the tune	Certification:	3 Suicide 6 Could not be determined	28e. Place of I building,	njury - At hor etc. <i>(Specify)</i>	me, farm, stre	eet, factory, office		28f.	. Location (Si City or Town	treet and Numb n, State)	er or Rura	l Route Number,
	To the Hospital or within 24 hours after To the Funerel Dirt completely tilled in it	edical (	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the besiner: On the basis and manner:	of examination	vledge, death on and/or inv	occurred at the timestigation, in my op	ne, date and pinion, deat	d place, and h occurred	due to the cat the time, d	ause(s) and ma late and place,	inner as st and due to	ated. the cause(s)
)	To the within To the comple	Med	29b. Signature and title of certifier	lou s	21	,	29c. License		•		7/Z/	/	
	10		30. Name and address of person who co	IN NO	2 5		FAIR DO	UNT	AVE	-Bai	Hirewe	1-10	d. 21286
	Sta Registr		31. Date file month Day, Xear)	Ser Hegis	trar's Signat	9 4	aarles						

Schlissler DOR'S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Day **Physician** 3, July L. SMITHERMAN 2004 1:35 p M /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurel Regional Hospital Prince George's Laurel If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year **Funeral** Days Hours Min. 1 □ M 2 1 1 F 218-34-1896 67 30. 1937 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6002 Maple Terrace 20707 U.S.A. or items 23a filed within 72 hours after deeth Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗓 ¥o 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XXIvo If Yes, Give Year or Dates: Specify White 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grade 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hugh Thorpe Sadie Elizabeth Sealock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred Smitherman 6002 Maple Terrace spouse Laurel, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Ivy Hill Cemetery July 7, 04 Laurel, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. week ancedia M00160 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Pneumothorax hour resulting in death) /Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease 20 years Sequentially list curvations, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed Tobacco abuse and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, funeral director, page 2 should be ¥XYes 2□No 3 Probably 4 □Unknown Coronary artery disease Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 242 No 1 ☐ Yes 2 🛛 Xio or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1XXXX atient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) After 1 XX atural 5 Pending 1 Tyes 2 No investigation М death the f 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dev. Year) 29h Signature and title of certifie 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Timothy McClain, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Laurel, Maryland

20707

Baltimore, Maryland 21215-0036

P.O. Box 68760.

321 Prince George Street

DHMH 17 Rev 1/2001

Registrar

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Mary Bernice Skinner 6  $2\tilde{4}$ 2004 7:40 a.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5921 Yorkwood Road Ba1to N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 218-22-6435 77 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examinan maintee notified at 1 XYes 2 No Md N/A Director Balto 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5921 Yorkwood Road 21239 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na sny injury or other traumatic event, it a Medic once. Private Homes Elementary/Secondary (0-12) Coltege (1-4or 5+) Domestic Worker 6th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leslie Wilson Mary 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bandie Wilson - Daughter 5921 Yorkwood Road Balto, Md 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 6-29-2004 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition ervico Physician resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 ₽ Division of Vital Hospitel or Attending Physician: in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 ☐ Yes 2 € M6 Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred : After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely the 29d. Date signed (Month, Day, Year) 29b. Signature samittle of certifig 29c. License number cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

			For Stete Registrar	State of	Maryland / Depa	artment of He		, ,	iene	21100	
	0		1. Decedent's Name (First, Middle, L					2. Date of Deat		3. Time of Death	
	Physicia /Medic		Avis Elizabet	<u>.</u>				JULY	01 200		
	Examin	er	4a. Facility Name (If not institution, g		er)	4b. City, Town, or I			4c. County of Dea	th	
	Funeral		Union Memorial H 5. Social Security Number 6.	Sex 7.	Age (In yrs. last birthday)	If Under 1 Year	imore If Under 24 Hrs.	8. Date of Birth	N/A 9. Bir	thplace (State or Foreign	
Ш	Director		220-24-8986	1 □ M 2/7/F	89 Yrs.	Months Days	Hours Min.	(Month, Day, March 1	Year) C	ountry) St Virginia	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
	Maryl -1 sho fied a	tor	Maryland	N/A	I	Baltimore				XiXiYes 2 □ No	
	th the	irec	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Co		
	ath wi	Funeral Director	1213 W. 40th Str				21211			USA	
	er de	nne	11. Marital Status  1 Never Married 2 Married	12. Was Decede Amed Force 1 \( \) Yes \( \)	es?	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi		
920	urs aff	by	3√√ Widowed 4 Divorced	If Yes, Give Year or Date	es:	1□Yes 🛣 No	Specify:		Specify:	white	
21215-0036	72 hours after death with the Maryland natural', or terms 23a or 28e-f show digal Examination must be notified at	Completed	15. Decedent's (Specify only highest of		(Give	dent's Usual Occupat	tion uring most of worki	na	16b. Kind of Business	/Industry	
121	within ene. than "	mpt	Elementary/Secondary (0-12)	College (1-4	or 5+)	DO NOT use retired) Lling cler	·le	м	D General	Hoopital	
d 2	filed within Hygiene. other than ant, the M		17. Father's Name (First, Middle, La	st)			18. Mother's Name			поѕртсат	
/lan	2 should be and Mental is marked of aumatic eve	To Be	William Albert S	immons			Laura 1	Edwards			
Maryland		3	19a. Informant's Name/Relationship Geraldine Plowma						City or Town, State, e, Marylar		
	of Health of Health fitam 27 r other tr		20a. Method of Disposition		20b. Place of Dispo				20c. Location - City or		
imo	0 0	١.,	1 ☐ Burial 我又Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec			e-Washingt		04	Laurel, Ma	ryland	
Baltimore,	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service Lic	ensee	B1	2. Name and Address irgee—Hens	of Facility s-Seitz ]	Funeral	Home. Inc.		
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau	sed the death. Do not ent	531 Falls er the mode of dving.	Road Ba	ltimore,	Home, Inc. Maryland	Approximate	
	Pnysician	ž Nije	Immediate Cause (Final	y one cause on eac	h line. / R F C T ノン	F HEA	PT F	A1/ 14	b F	Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a Due to (or	& EST IV as a consequence of): OCARDIA	- ISEN		711200	-		
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oʻ	an and rial-tra	Examin	resulting in death) Last	Due to (or	as a consequence of):						
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	To the Hospitel or within 24 hours after To the Funeral Director completely filled in the Funeral C	edicai	29a. Certifier 1 - Certifying I (Check only one)	Physicien: To the be eminer: On the basi and manner	est of my knowledge, death s of examination and/or in stated.	n occurred at the time vestigation, in my opin	e, date and place, a nion, death occurre	and due to the car ad at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License			d. Date signed (Monti	,	
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			Ragistrar  1. Decedent's Name (First, Middle,	Last)		rimoaro	Dodin	2. Date of Dea		3. Time of Death
	Physicia /Medic		Clifton	Telli	inaton			June.	29 2004	+ 11:08 A
×	Examin		4a. Facility Name (If not institution,	give street and number)	).	4b. City, Tow	m, or Location of Deat	h	4c. County of De	ath
				ss Ave	aum lant hirthdau	Bat.	tomore	9 Date of Bird		irthologo (Class or Consist
	Funeral Director		5. Social Security Number 578 12 9536	i. Sex 1 M 2 ☐ F	n yrs. last birthday, \$\alpha 2 \text{ Yrs.}		ays Hours Min.		(Year) 1920	inthplace (State or Foreign Country)
-00	ס		Usual Residence of Decedent		0.5			1103101	112	
	arylar show	2	10a. State 10b. County	16	Oc. City, Town or L					10d. Inside City Limits 1°XYes 2 ☐ No
	28e-f	Director	10e. Street and Number		Baltin	10f. Zip Coo	de		10g. Citizen of What C	Country?
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36	s afte	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 MNo If Yes, Give Year or Dates:		1 ☐ Yes 2				lack
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anc	ould be fi Mental P arked of affic ever	o Be	Tassia. Tall	inaton				2 Mac		
	and Ment and Ment sumarked	F	19a. Informant's Name/Relationshi	(Type, Print)	19b. Mail	ing Address (St			r, City or Town, State,	Zip Code)
	and 2 lealth a m 27 li		Milton Tellin	aton / Nepher	U 20M	ountai	n Green	Cir. Ba	HO.MD	21244
O .	of E		20a. Method of Disposition  1   Burial 2 □ Cremation 3	- 1	20b. Place of Disp cemetery, cre	osition (Name of other	place)	Date	20c. Location - City o	r Town, State
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	18.5	П	3a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that caused the	e death. Do not en	nter the mode of	dying, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
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	death e atte	iciai	in the past 12 months?	1 Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown		□Ectopic pregn □ Other (s <i>pecif</i>			Month	Day Year
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	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	<u></u>	(Check only 2 Madical E.	Physician: To the best of n xaminer: On the basis of ex	amination and/or in	th occurred at the	ne time, date and plac my opinion, death occ	e, and due to the ourred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	ithin 2 o the	Medic	one) 29b. Signature and title of pertifier	and manner stated	3.	29c. Li	cense number		29d. Date signed (Moi	nth, Day, Year)
	⊢≯F 8		1 Cart	" me (mo		T	146/18	i	1111.	20014
	-		30. Name an address of person w	ho completed cause of deat	h (Item 23a) (Type	, Print)	0/110	0 10	July of	1 2009
	9		JANET COOL	EN MO	1447	YOVK	Kd Lu	Therull	IC MD	+1093
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Soons	21			***************************************

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			Decedent's Name (First, Middle, Last)		7711110410 0		2. Date of Dea		3. Time of Death
	Physici		Tanet		Touris	_  .	Month	Day Ye	O I C DM
	/Medi		4a. Facility Name (If not institution, give street and no	umber)		Location of Death	July	4c. County of D	34
1	Examir	ier		1 (	011			R	oau i
	Europal		Johns Hoptains Barrieu  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	La Him	Birthplace (State or Foreign
	Funeral Director		723–18–4413	84 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) July 29	, 1919 N	Country)
			Usual Residence of Decedent	04			July 29	, 1919 N	ew York
	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-1 show item Mailcal Exer it at motified at		10a. State 10b. County	10c. City, Town or L	Location				10d. Inside City Limits
	Ma	ţō	Maryland Baltimore	Essex					1 ☐ Yes 2 ☐XNo
	1 the	rec	10e. Street and Number	ESSEY	10f. Zip Code		1	0g. Citizen of What	Country?
	3a o	Funeral Director	810 Myrth Avenue		21 221				,
	ns 2	era		cedent Ever in U.S. 13.	. Was Decedent of His	spanic Origin? (Spec		J. S. A.	merican Indian,
10	fter of the rest	F	Armed F	orces?	If Yes, specify Cubar	n, Mexican, Puèrto F	Rican, etc.)		/hite, etc.
33	Irs a	by	3 X Widowed 4 □ Divorced If Yes, G	X□ No live Dates:	1 ☐ Yes 2 💢 No	Specify:		Specify:	White
21215-0036	2 hou	ed	15. Decedent's Education	16a. Dec	edent's Usual Occupa	ation		16b. Kind of Busine	
15	in 7	Completed	(Specify only highest grade completed	(Giv	e kind of work done d DO NOT use retired)	luring most of workin )	g		
12	iene	lwo	Elementary/Secondary (0-12) College	(1-4or 5+)	ator		1	Baltimore	County hool System
	filed Hygir other ent, t		17. Father's Name (First, Middle, Last)		401	18. Mother's Name			noor bystem
an	d be ental ked c	To Be	Samuel Sternberg			Adelaide			
Maryland	2 should be filed within and Mental Hygiene. is marked other than eumatic event, the Ms	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street a.			reen City or Town Stat	a. Zin Code)
N			Parhara Carolo Iittle (						
Ġ,	s 1 and of Health item 27 other tr		Barbara Carole Little ( 20a. Method of Disposition	20b. Place of Disr	2 Myrth Average of Sematory or other place	venue Ess		cyland 21, 20c. Location - City	
٥	0 0		1X Burial 2 ☐ Cremation 3 ☐ Removal from	Jale		7/8	₹		
Ë	t. Pag rtment rtent: i		'4 □Donation 5 □Other (Specify)		of Faith (		)4 I	Baltimore	, Maryland
Baltimore,	permit. Pag Depertment Importent: i any injury o		21. Signature of Funeral Service Licensee	P	22. Name and Address Bruzdzinski	s of Facility Funeral	Home Di	7	
	0 U = 6 O		Muchael C. Jaffe	an Sr. T	ruzdzinski 407 old Ea	istern Ave	nue Es	ssex, Mar	yland 21221
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not er each line.	nter the mode of dying	g, such as cardiac or	respiratory arre	est,	Interval Between
W	Pnysician		Immediate Cause (Final disease or condition	cute Re	enal Fe	alure			Onset and Death
	/Medical		resulting in death)	(or as a consequence of):		4.101			- J ways
	Examiner		Sequentially list conditions b.	VPEr kale	mia				3 days
		Jer	Sequentially list conditions, if any leading to knowledge cause. Enter Underlying Cause (Disease or injury that initiated events c.	(b) es a consequence of):					
	outec Id ansi	Examiner	Cause (Disease or injury that initiated events	100 58051	5				3 days
ó	exection and arrial-to	Ex	resulting in death) Last Due to	(or as a conseque ce of):					
8760	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d.						1
68	ificat g phy as th	edi							
ŏ	leath certific attending p i for use as	Physician/Me		utcome of pregnancy				23d. Date of	delivery
m	leath atte	cia	in the past 12 months?		☐Ectopic pregnancy ☐ Other (specify)			Month	Day Year
Ö	t the de by the tached	ıysi	9 ☐ Unknown 9 ☐ Unkr						
٦	res that igned b be deta		Part II. Other significant conditions contributing to contributing the contributing to contributing the contributing to contributing the contributing to contributing the	death but not resulting in the	underlying cause giver	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ds	uires sign	d by					1 ☐ Ye	s 2 1 No 3	Probably 4 Unknown
Records,	w require been si should b	Completed			-		0.1.146		
3e	has has	шb					24a. Was ar autops perforn	y prior t	autopsy findings available o completion of cause of
		CO						ned? death 2 2 No 1 □ Y	
Vital	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		7	26. Place of Death	Check onl one	9	
of	hys this al dii	2		Impatient 2 ER/Outpatie		4 LI Nursing Home		nce 6 Other (S	pecify)
		iuo	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Mor	of Injury 28b. Time on th, Day Year) 28b. Time of Injury	of 28c. Injury Work	at 28	d. Describe ho	w injury occurred	
9.	uttendii death. ctor: A y the fu	ati	2 Accident investigation		M 1 □ Y	es 2 No			
Division	of or Attend after death Director: , d in by the f	Certification;	3 Suicide 6 Could not be determined 28e. Plac build	e of Injury - At home, farm, st ling, etc. (Specily)	treet, factory, office	28	If. Location (Str City or Town	reet and Number or , State)	Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Cer				1		,	
	hou uner uner	cal	29a. Certifier 1 Certifying Physicien: To th	e best of my knowledge, dea	th occurred at the time	e, date and place, an	d due to the ca	use(s) and manner	as stated.
	To the Hospitel of within 24 hours all To the Funerel D completely filled in	Medical	one) and mar	nner stated.	nvestigation, in my opi	inion, death occurred	at the time, ga	ite and place, and d	ue to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		29c. License		29	d. Date signed (Mo	nth, Day, Year)
	s s			- Medica	KES	000-2		July 5	2004
	01		30. Name and address of person who completed cau	ise of death (Item 23a) (Type	, Print)	Tou	ver ila	Doctors	Lounge,
	1		Damian Chaupin.	11	Lins Hospi	ital 600	North 1	Unifo CLAP	+ BILLIAM
	Sta	te		Registrar's Signature	-113		- p-0, (w. 1	-CITE SIX CO	et Baltimore, Maryland 21287
	Registr		JUL U 6 2004 August	wa B	loc. d.				Fund Cicol

			ricuse	Or to the t				. 10		.ogibio.		
			For State	State of Maryla	•				-	0001	21100	
			Registrar		Ce	rtificate of	Death		Reg. No.	2004	41113	
	Physicia	an	Decedent's Name (First, Middle, Land)					2. Date of Dea Month	Day 2	Year	3. Time of Death 7:40 AM	
	/Medic	al	MILDRED	TRIPF	777	1		7		04		
	Examin	er	4a. Facility Name (If not institution, gi	A 1		4b. City, Town, o	-	URNIE		NNE	ARUNDE	
			MARINE 12- 5. Social Security Number 6.		. last birthday)	If Under 1 Year	If Under 24 h					
	Funeral Director		235-20-2229	X -	30 Yrs.	Months Days		Hrs. 8. Date of Birt Month, Day Oct. 7,	1923	WV	place (State or Foreign Intry)	
8		1	Usual Residence of Decedent									
	yland		10a. State 10b. County	10c. C	ity, Town or L	ocation					10d. Inside City Limits	
	Mar Me-f al	tor	MD Caroli	ne I	Ridgely						1 Tes 2 No	
	th the	lre	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	-	
	in 72 hours after death with the Maryland "natural", or Items 23a or 28e-f ahow splical Exercited from the recitied at	Funeral Director	12741 Eveland Ro	oad			21660			U.S.A.		
	rdes	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? an, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	. 1	<ol> <li>Race - Amer Black, White</li> </ol>		
20	or it	by F	1 Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ Yes 22 No		1 ☐ Yes 💥 No	Specify:		5	Specify:	hite	
Š	hour.	d D	15. Decedent's 8	Year or Dates:	16a Dece	edent's Usual Occup	nation	1	16h Kin	d of Business/l		
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7	the see	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Sewi	ng Instru	uctor		Ret	ai1		
0	a filed of her vent, it	Be C	17. Father's Name (First, Middle, Las	it)	'		18. Mother's	Name (First, Middle,	Maiden S	Sumame)		
<u>a</u>	T 2 2 9	To B	Charles E. Mace				Corba	a J. Engla	ınd			
Maryland 21215-0036	should and Men s marke umatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ing Address (Street	and Number of	r Rural Route Numbe	r, City or	Town, State, Z	ip Code)	
	s 1 and 2 should Health and Mer tem 27 Is marke other treumatic		Mr. William Tripp	ett, III / sor	n 1274	1 Eveland	d Road,	Ridgely,	Mary	land 21	660	
e e	of Hea		20a. Method of Disposition 1 △Burial 2 □ Cremation 3		Place of Disponentery, cre	osition (Name of matory or other pla	ice)	Date	20c. Loc	ation - City or 1	Town, State	
Ĕ	Pages nent of ant: If It ary or o		`4 □Donation 5 □ Other (Spec	sify) St	ınset M	lemory Gar	rdens Ju	1y 7, 2004	Par	kersbur	g, WV	
Baltimore,	permit. Pages Department of I Important: If It any injury or o		21. Signature of Furiera Service Licensee 22. Name and Address of Facility Singleto							ral Hom	ne P.A.	
n	Dep Dep Imp		100	V101220			Avenue S	S.W., Glen	Bur	nie, MD	21061	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	y one cause on each line.					rest.		Approximate Interval Between Onset and Death	
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	/Medical Examiner		resulting in death)	Due to (or as a conse	<u></u>		_		-1			
录	LAdilline	_	Sequentially list conditions,	b. PARKI	1 NO SC	SN J	EME	NTI	4		5/19	
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence or):						/	
	and I-tran	Examiner	that initiated events resulting in death) Last	cDue to (or as a conse	equence of):							
9	ate be executed hysician and he burial-transit	caiE										
687	icate phys			d								
Box	leath certificate attending phy I for use as the	Z/M	IF FEMALE: 23b. Was decedent pregnant			23	23d. Date of delivery					
ň	d for	cia	in the past 12 months?	1□Live birth 2□Fe 4□Pregnant at time of		□Ectopic pregnanc □ Other (specify) _	;y			Month	Day Year	
o.	that the de led by the a detached f	hys	9 Unknown	9□ Unknown								
ري. ص	signed to	by Physician/Med	Part II. Other significant conditions				ven in Part !.	23e. Did to	obacco us	e contribute to	the cause of death?	
ğ	w require been sig should b	edt	RIGHT BREAST CANCEIZ							1 Yes 2 No 3 Probably 4 Unknow		
000	aw re	plet	OSTEDAR	2+HICE TI	5			24a. Was		24b. Were au	lopsy findings available ompletion of cause of	
The law reducings of the law r							rmed?	death?	2 □ No			
ta	rtifica stor, p	BeC	25. Was case referred to medical examiner?				26. Place of	Death (Check only o	ne)			
<b>&gt;</b>	nysic nis ce direc	To E	1 Yes 20 10	Hospital: 1 ☐ Inpatient 2 (	☐ ER/Outpatie	ent 3 DOA	her: 4 Nursir	ng Home 5 Resid	dence 6	Other (Spec	sify)	
Division of	ng Pł fter tł neral	:io	27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time ( Injury	Wo	ork?	28d. Describe I	now injury occurred			
0	andii eath. or: A he fu	Certification:	2 Accident investigati			M 1	Yes 2 No					
<u>=</u>	l or Att after de Direct I in by t	Ě	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			treet, factory, office		28f. Location (S City or Tov	Street and vn, State)	Number or Ru	ral Route Number,	
	To the Hospitel or Attanding Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: Atter this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.		CO CONTINUE AND	Dhuaisian Taritar		4h			******			
	Hosp 14 hol Fune tely fi	ica	29a. Certifier (Check only one)  Certifying I  Certifying I  Medical Exp	Physician: To the best of my ki eminer: On the basis of examin	nowledge, dea nation and/or ii	th occurred at the t nvestigation, in my	ime, date and p opinion, death o	occurred at the time,	date and	and manner as place, and due	to the cause(s)	
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certifier	and manner stated.	<b>—</b>	29c. License number 29d. Date signed (Month, Dey, Year)						
	8 4 £ 4		· 1/1	1991	7	1020	519					
7	10		30. Name and address of person wh	o completed cause of estate //t	em 23a) (Type	Print		- 1	0	0	. /	
	W		RICHAR	( 1	E 17	CRAI	N To	SABO	GLE	N BU	ENE, MI	
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	D	100	1111 0 0 00		1. 1							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Year Month **Physician** JASON 1022 AM HRJUN VERMA Ju/4 02 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner HOPKINS If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) TheJohns -USPI +L 6. Sex 7. Age (n yrs. last birthday) 5. Social Security Number Funeral Birthplace (State or Foreign Country) 1⊠M 2□F Yrs Director N/A Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 ie marked other then "nature! ~ " any injury or other traumatic event." 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes % No Maryland Howard Elkridae 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 6092 Rock Glen Drive 21075 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Asian 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Infant Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Davinder Kumar Rima Datta Verma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rima Verma - Mother 6092 Rock Glen Drive Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XOBurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Pk. 7/4/04 Elkridge, Maryland 22. Name and Address of Facility
Gary L. Kaufman Funeral Home At MMP. 21. Signature of Funeral Service Licensee 7250 Washington Blvd. Elkridge, Maryland 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Fulmirant days Heute /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Phyeicien: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 23 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an has autopsy performed? certificate 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA this Director: After that in by the funeral Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} \) within 24 hours a To the Funeral L Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of

31, Date filed (Month, Day,

Year)

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

WOLFE

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		S	State of Maryland / D				ie.				
		1 - Stata Registrar		Certificate of D	eath	Reg. Nø.	4 21105				
Physi /Med	cian dical	Decedent's Name (First, Middle, Last)     LIDIYA	I.	VOLIS	Ju	INE 30, 20					
Exam	iner	4a. Facility Name (If not institution, give stre SINA1 HOSPITA		4b. City, Town, or L		4c. County of	N/A				
Funera Directo		5. Social Security Number 6. Sex 1 Number 1 Number 6. Sex 1 Number	7. Age (In yrs. last bir	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. 8. Da	tte of Birth (1921)	). Birthplace (State or Foreign Country) UKRAINE				
death with the Maryland ms 23a or 28a-f show I must be notified at		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	n or Location ALTIMORE			10d. Inside City Limits 1    Yes 2 □ No				
er death with the Marylan Items 23a or 28a-f show ner must be notified at	recto	MD N/A	l Di	10f. Zip Code		10g. Citizen of Wh					
ath with 23a o ust be	raiD	3601 FORDS LANE #20	)4		21215		U.S.A.				
ier ier A Ite	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 🎇 Widowed 4 □ Divorced	Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 N No If Yes, Give Year or Dates:	13. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 🏋 No	panic Origin? (Specify Young) Mexican, Puerto Rican, Specify:	es or No- etc.) 14. Race - Black, Specify:	American Indian, White, etc. WHITE				
S585	ompieted	15. Decedent's Educat (Specify only highest grade c		Decedent's Usual Occupati (Give kind of work done dur life, DO NOT use retired)	on ring most of working	16b, Kind of Busin	ness/Industry				
N N	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	CCOUNTANT		ACCOUNT	ING				
- 3 AF	ם כ	17. Father's Name (First, Middle, Last)	7.6			, Middle, Maiden Sumame)	CDADACH				
FERRE SULZEGEN	2	JOSEPH  19a. Informant's Name/Relationship (Type,		OLIS  Mailing Address (Street and	SOFIYA	e Number, City or Town, St.	GRAPACH				
13 FOLOU				601 FORDS LAN							
1 2 U & C 508- 11-28 508- 11-28 508- 11-28 508- 11-28 508- 11-28 508- 11-28 508- 11-28	í	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Rem	noval from State cemeter	f Disposition (Name of ry, crematory or other place)		20c. Location - Ci					
A SEE SEE		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Fineral Service Licensee</li> </ul>	BALIII	MORE HEBREW C 22. Name and Address		VINSON & BRO	ERSTOWN, MD				
B P P P	ă	Kotal -	4		RSTOWN ROAD	- PIKESVILL	-				
Physicia /Medica Examine	il	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (final disease or condition resulting in death)  Sequentially list conditions,  b		A OF PAN		natory arrost,	Approximate Interval Between Onset and Death  1 yr  1 yr				
68760, ificate be executed g physician and as the burial-transit	edicai Examiner	if any, leading to immediate cause. Enter Underking Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence				•				
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cords, P. w requires that been signed by should be deta	by	Part II. Other significant conditions contri		, , ,			o use contribute to the cause of death?				
Records, he law requires t he has been signe	Completed		es Melitus,		-						
Rec The lav te has age 2:	ошо	hyperlipiden		24a. Was an autopsy findings availad prior to completion of cause death?							
f Vital Roysician: The is certificate hidirector, page	BeC	25. Was case referred to medical examiner?	^	26. Place of Death (Chec	1						
of V Physic rthis co	은	1 ☐ Yes 2 ☐ No Hos		me 5 Residence 6 Other (Specify)  28d. Describe how injury occurred							
Jing Afte fune	Certification:	27. Manner of Death 1 Statural 5 Pending investigation 3 Suicide 4 Homicide 4 Homicide 28a. Date of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No 28b. Time of Injury 4 Work? 1 Yes 2 No 28b. Time of Injury 4 Work? 1 Yes 2 No 28b. Time of Injury 4 Work? 1 Yes 2 No 28b. Date of Injury 4 Work? 1 Yes 2 No 28b. Describe how injury occurred									
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medicai Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To the within To the comple	Me	29b. Signature and title of certifier		29c License r	number	29d. Date signed (f	Month, Day, Year)				
		MULUGETA	2. FISINA, A	MA P/8:	517	JUNE	E30,2004				
/		30. Name and address of person who com	oleted cause of death (Item 23a) (	(Type, Print)	LEST REIL	IFAFDE AVE	30,2004 ,BMJMOLE,M				
	State	31. Date filed (Month, Day, Year)	32, Registrar's Signature	/	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	JOURCE TIYE	1 STICK INVECT, IN				
Regi	strar	1111 0 0 0001	h. P. wes M	1							

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Year Month **Physician** 1 2:10p M Wilks Mamie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Manor Care Towson Baltimore Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Man) (Month, Day, Man) (Month, Day, Man) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2🗚F ۷a. 231-28-2680 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show the Medical Examiner must be notified at 1X Yes 2 □ No Baltimore Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a or USA 21213 3314 Lawnview Ave. Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: if flam 27 is marked other there any injury or other traumant. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) 12th grade College (1-4or 5+) Craddock Shoe Factory Laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Butts Richard Martha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3314 Lawnview Ave., Baltimore, Md. Nephew Alfred N. Simmons 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Macondia Bapt. Ch. 7-4-04 Emporia, VA. \* 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 21202 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave. l adip wane Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician C14614 COLONALA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed be detached for use as the burial-transit the attending physician and Due to (or as a consequence of): O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 70 1 Yes 1 Yes 2 No within 24 hours after death. To tha Funaral Diractor: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 orke took 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 6 2004 Registrar

			For State Registrar	State o	of Marylar		artment of H rtificate of I		d Mental Hy	giene ()	14 3	21107		
			1. Decedent's Name (First, Middle,	, Last)					2. Date of D Month	eath Day	Voor	3. Time of Death		
	Physici /Medio		Ruth E.	Wood					July			2 · 15 A M		
	Examin		4a. Facility Name (If not institution,		m <i>ber)</i>		4b. City, Town, or	Location of De						
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	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 H	Irs. 8. Date of B	irth				
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	ith th	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	try?		
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	tama tama	Funeral	11. Marital Status	Armed F			Nas Decedent of H f Yes, specify Cuba	ispanic Origin? ın, Mexican, Pu	? (Specify Yes or N uerto Rican, etc.)					
36	within 72 hours after death with the Maryland ane. than "natural", or itama 23a or 28a-1 show ha Nedleal Eraminar mual be notified at	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	if Yes, Gi	veX No		1 □ Yes 2∏ No	Specify:		Specia	v: Whi	te		
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an	0 to 0	To Be	Henry F. Bau	uereis				G	ertrude N	1. Schne	3. Time of Death 2004 2:15A M Country of Death  Baltimore  9. Birthplace (State or Foreign Country) Maryland  10d. Inside City Limits 1 Yes 2 No  zen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: White and of Business/Industry  BGE  Sumame) hneider  Town, State, Zip Code)  re, Md 21214 cation - City or Town, State altimore, MD  Inc. MD 21228  Approximate Interval Between Onset and Death  3d. Date of delivery Month Day Year  See contribute to the cause of death? No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No  Cocurred  A Number or Rural Route Number,  and manner as stated. place and (Month, Day, Year)  A signed (Month, Day, Year)			
Maryland	Should No.	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	g Address (Street a	and Number or	Rural Route Numi	per, City or Town	, State, Zip	Code)		
S	and 2 sealth ar m 27 is		Charles E. Gal	latin /Fr	hrai	3220	E. North	nern Pa	rkway Bal	timore.	Md 2	1214		
ē,			20a. Method of Disposition	iacin / i i	20b. F	Place of Dispo	sition (Name of natory or other place		Date					
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Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service L											
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	Physician													
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		on:	27. Manner of Death  1    Natural 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe	how injury occur	red			
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	To the Hospital of within 24 hours at To the Funeral D. Completely filled in	Med	29b. Signature and title of certifier	W112 11(01)			29c. License	number		29d. Date signe	d (Month, L	Day, Year)		
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	A		30. Name and address of person w	who completed caus		n 23a) (Tyne	Print)	1	]	-417	- 2	/		
			1205 York	Road	1, 50	erte:	Print) 38, Lu Sporks	ether	ville,	MD	210	93		
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Physicia		Decedent's Name (First, Middle, La     Anna Wynn	st)							2. Date of D Month July		2004	ar	ime of Death
/Medic Examin		4a. Facility Name (If not institution, giv	e street and num	ber)		4b. City	, Town, or	Location of	of Death	oury	4	c. County of D		-1.1.2/1
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Funeral Director		5/9-24-8803	M ZFF	7. Age (In yrs. 8	. last birthday) 2 Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of B (Month, L June	ay, Year	922 g.	Birthplace (S Country) Ohio	State or Foreig
and and		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Ins	ide City Limit
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72 hours after death with the Maryland netural; or tems 23a or 28e-f show lical Examinant intercolling at	Director	10e. Street and Number	iici y	Bethesda 104. Zip Code 109							10g. C	itizen of What	Country?	
23a c		5721 Gosvenor La												
tems	Funeral	11. Marital Status	12. Was Deced	ces?	J.S. 13.	Was Dece If Yes, sp	edent of H ecify Cuba	ispanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	lo-		merican Ind Vhite, etc.	ian,
ours after death with the Marylan rel', or items 23a or 28e-f show Exerting fridel be indified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes If Yes, Give Year or Da	<del>)</del>		1 🗆 Yes	2∏ No	Specify:				Specify:	White	5
"netural", dical Exe	Completed	15. Decedent's E			16a. Dece			ation during mos	t of work	ina	16b. I	Kind of Busine	ess/Industry	
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B a b s	To Be	Ernest Hilton							Mari		-,		NK.	
\$ P E E		19a. Informant's Name/Relationship (	Type, Print)		19b. Maili	ng Addres	s (Street				ber, City	or Town, Stat		
1 and 2 Health a tem 27 is		George Day/Cousin	1		PO Bo	x 19	1 Cu	Lpepe	r. V	irgini	a 22	701		
0 0		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐			Place of Dispo cemetery, crei	sition (Na	rme of		,	Date	20c. L	ocation - City	or Town, St	ate
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permit. Pag Department Important: any injury once.		21. Signature of Funderal Service Ligation  Thomas Gregor	ty		(	rema 299 F	nd Address tion rede	Soci Soci rick	ety Road	Of Mar Balti	ylan more	d Inc. , MD 2	1228	
Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that ca one cause on ea	ch line.									Appro	eximate al Between and Death
/Medical Examiner		resulting in death)		or as a conse	quence of):									
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death certific e attending p d for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		th 2 Feta	al death 3[	Ectopic p Other (s	pregnancy pecify)		D USES			23d. Date of Month	delivery Day	Year
Se us	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.												
The law requir ate has been si page 2 should	ompleted									perl	opsy formed?	prior	to completio	dings available n of cause of
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© ∞ 5	OB	examiner? 1 ☐ Yes 2 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA								-	6 Other (S	Specify)	
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vitin 24 hours after death. To the Funeral Director: A completely filled in by the t	Certification;	3 Suicide 6 Could not be determined	286. Place	of Injury - At h g, etc. (Speci	nome, farm, str	eet, facto	ry, office			28f. Location City or To	(Street a. own, Stat	nd Number or e)	Rural Route	Number,
24 hours	edical (	29a. Certifier Chack only one) Certifier 2 Medical Example 2	ysician: To the l niner: On the ba and mann	sis of examina	owledge, deatl ation and/or in	occurre vestigatio	at the time n, in my of	e, date an pinion, dea	d place, a	and due to the ed at the time	cause(s	s) and manner od place, and	r as stated. due to the ca	use(s)
within To the	Me	29b. Signature and title of certifier					c. License					ate signed (M	-	
				-			H 50	×28	JULY			4/5	2009	1
1		30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type,	Print)	ve R	soule:	vertek	SUIT	E 30	O Rex	KVILLE,	Mp Ze3
Sta Registr		31. Date filed (Month, Day, Year)  JUL 0 6 2004	32. Re	gistrar's Sign		art							<u>`</u>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Mary Virginia Weatherholtz 04 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Bosedale

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1933 Franklin Square Hospital Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 200F Yrs. 70 Director 213-30-8591 Maryland Usual Residence of Decedent 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits other treumetic event, the Medical Examiner must be notified at Maryland Baltimore Essex 1 Yes 2 No Director 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? 1544 Galena Road 21221 Items 23e U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★★No If Yes, Give Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ō 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Weatherholtz Many Office Worker Mobile Home Mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental I Elmer Smith Catherine Bock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is Walter Weatherholtz (Husband) 1544 Galena Road, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ Holly Hill Mem. Gard. July 5,2004 Baltimore, Maryland <sup>1</sup> 4 □ Donation 5 □ Other (Specify) any injury 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.

Maryl 21. Signature of Funeral Service I Sensee 1407 Old Eastern Avenue, Essex, Maryland 21221 Exert the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 5 days **Physician** Aspiration Preumonia resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy ò Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, pe 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown end Stage liver disease funeral director, page 2 should Be Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Coagulopathy certificate has anemia 2 2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 TER/Outpatient 1. Impatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one)

Registrar

29b. Signature and title of certifie

(Item 23a) (Type, Print)

9000

completed cause of death

32. Registrar's Signature

29c. License number

3quare Drive

0005647

4-04284			State o	f Marvlan	d / Depa	rtment of H	ealth ar	nd Mental H	vaiene		
.E.S		1 - For State Registrar		, <b>,</b>	•	tificate of L			Reg. No.	nnl.	21110
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Physicia		DENISE	RANDY	WILLIAN	ИC			July	Day	2004	5:50 aм
/ /Medic Examin		4a. Facility Name (If not institution, give	e street and nui		10	4b. City, Town, or	Location of I			County of Death	
	•	Bon Secours Hos	pital		i	Baltimo	ore		В	altimore	∈ City
Funeral		5. Social Security Number 6. S		7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hours		irth Day, Year)	9. Birth	place (State or Foreign
Director		214-58-7209	□ M 2.XXF	5.	l Yrs.	Wionais Days	riours	July	6 195		RYLAND
pu &		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation					10d. Inside City Limits
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the A	Director	MARYLAND N/A  10e. Street and Number			DALITI	10f. Zip Code			10g Citi	zen of What Cou	
With Ba or	₫	2226 W SARATOGA	CUDEEU			21223					nuy:
seath ms 23	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.	S. 13. V		spanic Origin	n? (Specify Yes or N Puerto Rican, etc.)		.S.A. 14. Race - Ameri	can Indian,
of the control of the	Fun	1. Xiever Married 2 ☐ Married	Armed Fo	2.XXIO	1			Puerto Rican, etc.)		Black, White,	etc.
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5-0 72 hc	Completed	15. Decedent's Ed (Specify only highest gra				lent's Usual Occupa		of working	16b. Kir	nd of Business/In	dustry
22 aftin	du	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. I	OO NOT use retired)		· · · · · · · · · · · · · · · · · · ·			
Baltimore, Maryland 21215-0036 sermit. Pages I and 2 should be filed within 72 hours atl Department of Health and Mental Plygiene. mportant: if tiem 27 is marked other than "natural", or any injury or other traumatic event, the Medical Engra page.		12th grade			PAS	TRY BAKER		- No		OD SOURC	E
IOTE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland to Heatth and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Evardinar must be notified at	Be	17. Father's Name (First, Middle, Last)						s Name <i>(First, Middl</i>	e, Maiden .	Sumame)	
ylo	P	DENNIS WILLIAMS	E D-(-4)		10h M 10h			NE KEENE		- 0 - 7	
Mal d 2 st th and 7 is r 7 is r	G	19a. Informant's Name/Relationship (						or Rural Route Num			Code)
G, l	1	Randolph E. Will 20a. Method of Disposition	ıams/Br	20b. Pf	lace of Dispo	sition (Name of	3 6 6 7 7 3	Aurora, Co		80015 cation - City or To	own. State
imore, M Pages 1 and 2 nent of Health, a ant: If item 27 i		1 Burial 2 Cremation 3 □		State	-	natory or other place					
Baltimo	1	*4 □ Donation 5 □ Other (Specify 21. Signature of Funer Service Licer	-	NE		EDRAL CEM  Name and Address		07-07-04	BAL'	PIMORE,	MARYLAND
Balt permit. Depart Import any init		mulan C	1		W		BROWN	COMMUNITY ENUE	FUNI	ERAL HOM	E P.A.
		23a Part1. Enter the disease, or com shock, or heart failure. List only	nications that cone cause on e	aused the death	. Do not ente	er the mode of dying	, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between
- Pnysician		Immediate Cause (Final disease or condition		Co	1001	Cauc	er				Onset and Death
/Medical Examiner		resulting in death)	Due to	or as a consequ	uence of):						
CXAIIIIIIEI		Sequentially list conditions,	b								
ed sit	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	or as a consequ	ience of):						
xecut and	Examiner	that initiated events resulting in death) Last	c	or as a consequ	ence of):	-					
I Records, P.O. Box 68760,  The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal E	l l	a								
687 ificate g phy as the	edic		. d								
Box 6 eath certific attending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregnar					2	3d. Date of delive	эгу
death death ad for	icia	in the past 12 months?	4□Pregn	irth 2 ☐ Fetal ant at time of de		Ectopic pregnancy Other (specify)				Month	Day Year
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S, — es tha igned	by F	Part II. Other significant conditions of	ontributing to de	eath but not resu	ulting in the ur	iderlying cause give	n in Part I.			/	ne cause of death?
ecords,	Completed								Yes 2	No 3 Prob	pably 4 Unknown
Reco	ple							24a. Wa auto	s an	prior to co	psy findings available mpletion of cause of
	Con							peri 1 ☐ Yes	formed? 2 No	death?	2 No
Vital R sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Manager					f Death (Check only	one)		
of \	2	1 XYes 2 No			ER/Outpatien		4 🗆 140121	ing Home 5 Res			y)
On C	lon	27. Manner of Death  1 ■ Natural 5 □ Pending		th, Day Year)	28b. Time of Injury	28c. Injury Work	?	28d. Describe	how injury	occurred	
ision ttend death death stor:	icat	2 Accident investigation 3 Suicide 6 Could not be		of Injune - At ho	mo farm str	M 1 □ Y	es 2 □ No		/Stmot one	i Number or Rura	al Pouta Number
Division of all or Attending Phy sefter death. I Director: After this din by the funeral	Certification:	4 Homicide determined	buildi	ng, etc. (Specify	)	set, factory, office		City or To	own, State)	114211001 01 11212	in noute number,
Division of Vita  To the Hospital or Attending Physician: within 24 hours effer death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	niner: On the ba	best of my know asis of examinat ner stated.	wledge, death ion and/or inv	occurred at the time estigation, in my op	e, date and p inion, death	place, and due to the occurred at the time	cause(s) a , date and	and manner as s place, and due to	tated.  the cause(s)
To the within To the comple	Me	29b. Signature and Ittle of dertifier	^			29c. License				signed (Month,	
n		1 Clark	eml)						Jul	-y 2, 200	J¬ <b>1</b> 
)	4	30. Name and address of person who like the second 111 Per	n Stree	et, Balt	imore,	Print) Maryland	1 2120	)1			
Sta	3	31. Date filed (Month, Day, Year)		egistrar's Signat		W -					
Registr	alf	JUL 6 200	4 120	Wes &	ADS	W					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State	of Maryla			nt of H te of L	ealth and N Death	lental Hy	giene Reg. NQ.	001	0.1	1 1 1
	Dhuaiai		Decedent's Name (First, Middle							2. Date of De		<del>UU</del> ↓	-3. 1	ime of Death
	Physici /Medio		James W. Wo	<u>-</u>						June 3	-	04		40 PM M
	Examin	er	4a. Fecility Name (If not institution				4b. City	, Town, or	Location of Death		4c. (	County of D	eath	
	Funeral		Home; 5062 Wrig	ht Avenue		s. last birthday)		altimo	ore If Under 24 Hrs.	8. Date of Bi	rth	N/A	Birthplace //	State or Foreign
в	Director		219-26-8541	1 <b>X</b> XM 2□ F		66 Yrs.	Months	Days	Hours Min.	(Month, Da March	ay, Year)	38 M	Country) [arvlar	State or Foreign
	put *		Usual Residence of Decedent  10a. State 10b. County		100.0	City, Town or Lo	acation							
	Maryla f sho	٥	Maryland	N/A	100.0		timo	^_						ide City Limits ☐Yes 2 □ No
	288-	rect	10e. Street and Number			-41		p Code			10g. Citiz	en of What		-
	th with	aiD	5062 Wright Ave	nue				2	21205		U	SA		
	tems er ms	Funeral Director	11. Marital Status	Armed F			Was Dec	edent of His	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	o- 1		merican Indi	ian,
36	rs afte	by Fi	1 ☐ Never Married XXX Mar: 3 ☐ Widowed 4 ☐ Divorced	ned XXYes	2 🗆 No live Dates 1960-	61	1 🗆 Yes	XX No	Specify:			Specify:	white	2
9	in 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show goteal Examiner must be notified at	ted	15. Deceden	it's Education		16a. Dece	dent's Us	ial Occupa	tion		16b. Kin	d of Busine	ss/Industry	
215	- 1	Completed	(Specify only highe Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT	ork done di use retired)	uring most of work	ring	-			
121	000		6th 17. Father's Name (First, Middle,	(1004)		Pri	nter		40 14-11-1-1	/E:			& Publ	ishing
Maryland 21215-0036	bd be	Be C	James Oliver Wo						18. Mother's Nam Grace	e ( <i>First, Middl</i> e e Mary	, Maiden S	iumame)		
Ž	s 1 and 2 should by f Health and Menta item 27 is merked other traumatic e	은	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Addres	s (Street a	nd Number or Run		er, City or	Town, State	e. Zip Code)	
	and 2 aith a 127 is		Gladys Ruth Wol	f (Wife	e)				venue Ba					
ore	iges 1 au it of Hea if item or othe	1	20a. Method of Disposition 1 ☐ Burial 2√√Cremation	3 DRemoval from		Place of Dispo	sition (Na	me of		Date			or Town, Sta	
Baltimore,	Peges tment of tant: If it jury or o		* 4 ☐ Donation 5 ☐ Other (S	(pecify)	Ba				con 7/4/2	2004	La	urel,	Mary1	and.
Bal	permit. Peges Department of Important: If i any injury or once.		21. Signatur Funeral Service	Licenses ,	fee.	Bu	urgee	-Hens	s of Facility SS-Seitz Road F	Funeral	L Home	e, Inc	c. nd 212	11
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90,	rcate be executed physician and s the burial-transit		resulting in death) Last	Due to	(or als a conse	quence of):	oras	LE	A. was		1		5	<i>y</i>
68760,		dical		d	rigere	VAC 19	eu.	910	W COW				<u> </u>	ND
Box 6	death certific e attending p d for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregi						23	3d. Date of	delivery	
	death	sicia	in the past 12 months? 1 ☐ Yes 2 No	4☐Preg	birth 2 ☐ Fe nant at time of		JEctopic p Other (s	regnancy pecify)				Month	Day	Year
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Records,	es Ded	by	Part II. Other significant condition	ons contributing to	death but not re	sulting in the ui	nderlying	cause give	n in Part I.	23e. Did t			to the caus Probably	e of death? 4  Unknown
900	aw Is b	Completed								24a. Was		24b. Were	autopsy find	lings available
	The ate h page	Com									ormed?	death		
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:					26. Place of Deat					
of	Phys or this aral dii	To To	1 ☐ Yes 2 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatien 28b. Time of		OA Cthei 28c. Injury Work	4   Nursing Ho	me 5 Residente 28d. Describe			pecify)	
ion	Attending ir death. ector: After by the fune	atio	1 Natural 5 Pendin 2 Accident investi	9	nth, Day Year)	Injury	М		? es 2 □ No		. ,			
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could determ	ined 286. Plac	e of Injury - At ding, etc. (Spec	home, farm, stre	eet, facto	y, office		28f. Location ( City or To	Street and wn, State)	Number or	Rural Route	Number,
	Hospitel or 24 hours afte Funerel Dir tely filled in l		29a. Certifier Certifyin	ng Physician: To th	e best of my kr	nowledge, death	1 occurred	I at the time	e, date and place,	and due to the	cause(s) a	nd manner	as stated.	
	the Ho in 24 th the Fu	edical	one)	and ma	basis of examin nner stated.	nation and/or inv	vestigation	n, in my opi	nion, death occurr	ed at the time,	date and p	lace, and d	lue to the car	use(s)
	To 1 To 1	Σ	29b. Signature and title of certifie	181 0	0			c. License			29d. Date	signed (Mo	onth, Day, Ye	ear)
	2		- Allinda	v Callia	rob	- 02-1 77		216	46		0'1/	01/0	14	
	$\sigma^{-}$		30. Name and address of person	Edul Pr	Co death (Ite	005 N.	Poin	+ Bh	d Baltin	noso. M	D 21	224		
- 10	Sta		31. Date filed (Month, Day, Year)	32.	Registrar's Sigr				J 03/4/II		- •			
	Registr	ar	JUL 0 6 20	ITA /re	man	4								

			For State Registrar	State of I	Marylan	-		of Hea	ilth and	d Mental Hy		_	21112
	Physici	an	1. Decedent's Name (First, Middle, H. Lawrenc							2. Date of De Month	ath Day	Year	3. Time of Death 4 8 : 2121 PM
}	/Medic Examin		4a. Facility Name (If not institution, g	give street and number		d	4b. City, Tov	wn, or Loc	Admin	eath		County of Deat	h
	Funeral		Saint Joseph  5. Social Security Number 6	. Sex 7.		last birthday)	If Under 1 Y		Under 24 H		th		timore  pplace (State or Foreign untry)
	Director		217-16-7616 Usual Residence of Decedent	1 <b>XX</b> M 2□ F		82 Yrs.	Months D	ays H	ours M	lin. (Month, Da April			cyland
	anyland show	_	10a. State 10b. County		10c. Cit	y, Town or Lo		. 1					10d. Inside City Limits
	ath with the Marylan 23a or 28e-f show 451 or nutified	Funeral Director	Maryland Bal  10e. Street and Number	timore		Г	ikesvi]				10g. Citi	zen of What Co	1 ☐ Yes 2XXNo untry?
	ath with	rai Di	806 Olmstead Roa					2120				USA	1
980	iges 1 and 2 should ba filad within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23a or 28e-f show or other traumatic event, it is Madical Examinational be notified at	ğ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Typyes 2 If Yes, Give Year or Date	es? □ No	1	Was Decedent If Yes, specify 1 ☐ Yes 2☐		nic Origin? lexican, Pu pecify:	(Specify Yes or No uerto Rican, etc.)	-	14. Race - Amer Black, White Specify: V	
21215-0036	n 72 ho "natur	Completed	15. Decedent's (Specify only highest	grade completed)		16a. Dece (Give	dent's Usual O kind of work of DO NOT use r	ccupation lone during	g most of	working	16b. Ki	nd of Business/I	ndustry
212	filad withir Hygiene. kther than ant, the W	Comp	Elementary/Secondary (0-12)	College (1-4d	or 5+)		Treasur	у Ад	ent			Governm	nent
land	ould ba filad Mental Hygid arked other atic event, I	To Be	17. Father's Name (First, Middle, La Herbert Lawrence		1			18.		Name <i>(First, Middle,</i> Bertie Rel			ria Armacost
Maryland	2 should and Men is marke raumatic	-	19a. Informant's Name/Relationship						Number or	Rural Route Numb	er, City o	Town, State, Z	ip Code)
	s 1 and f Health item 27 other tr	1	Nancy G. Wilhelm 20a. Method of Disposition	,	20b. F		Olmstea esition (Name of matory or other		ad	Pikesvill		ID 21208 cation - City or 1	
Baltimore,	permit. Pages. Department of I importent: If ite any injury or of once.	١,	1 ☐ Purial 2 ☐ Cremation 3 • 4 ☐ Donation 5 ☐ Other (Spe			uid Ri	dge Cem	eter	-	6/2004	Pik	esville	e, Maryland
Bal	permit. Pa Departmer Importent: any injury once.		21. Sign tur of Funeral Service Lic	Carpen	lu	- B <sub>1</sub>	2. Name and A urgee-H	ddress of lenss	-Seit	z Funeral Baltimor	. Hon	ne, Inc.	01011
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	omplications that causely one cause on each	sed the deat h line.	h. Do not ent	er the mode of	t dying, su	oad uch as card	Daltimoi diac or respiratory a	rest,	lary Land	21211 Approximate Interval Between Onset and Death
	Prysician /Medical	ř	Immediate Cause (Final disease or condition resulting in death)	u	MONIA as a conseq								011001 0110 000111
	Examiner	_	Sequentially list conditions,	SEPS:	IS								
	outad Id Pansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		as a conseq		R THR	OMBO	SIS				
60,	ate be executad hysician and the burial-transit	ical Exa	resulting in death) Last		as a conseq								
68760,	rtificate ng phys as the		is service	d									
P.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknowr	n 2 ∏ Feta tat time of d	Ideath 3□	Ectopic pregn Other (specif				2	3d. Date of deliments	very Day Year
Ś	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions	s contributing to death	h but not res	ulting in the u	nderlying caus	e given in	Part I.	23e. Did t	1		the cause of death?
al Record	The ate h page	Completed				_ ,					rmed? 2 X No	24b. Were aut prior to c death? 1 🗆 Yes	opsy findings available ompletion of cause of
f Vital	8 5	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 X Inpa	atient 2	ER/Outpatier	nt 3 DOA	Other		Death <i>(Check only o</i> g Home 5 ☐ Resid		☐Other (Spec	ify)
on of	ling After une		27. Manner of Death  1. Natural 5 Pending investigat	28a. Date of I (Month,		28b. Time of Injury	28c.	Injury at Work?	2 □ No	28d. Describe I	now injury	occurred	
Division	fter pirac in by	Certification:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	Injury - At ho	ome, farm, str y)	eet, factory, of			28f. Location (S City or Tox			ral Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Diracl completely filled in by	edicai	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the be aminer: On the basis and manner	s of examina	wledge, death tion and/or in	n occurred at the vestigation, in a	ne time, da my opinior	ate and pla n, death or	ace, and due to the ccurred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	Mith Common	Σ	29b. Signature and title of certifier	nello n	n-10			cense nur				signed (Month	
	167,		30. Name and address of person wh	o completed cause o	of death (Item	n 23a) (Type,	Print)	(1)(1)4)	1410		-4 64	G1 / 6	
	Sta	te.	JOGINDER P. N 31. Date filed (Month, Day, Year)	<u>1ЕНТА. М.</u> 32. Regi	. D . istrar's Signa		OSLER	DRI	VE T	OWSON, I	MARY	LAND 3	1204
	Registr		JUL 0 6 200	. / >	mar		doorks	/					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, Month Day Year **Physician** OR 3.2704 200 D 02 /Medical 4b. City, Town, or Location of Death 4c. County of Death Name (If not instit Examiner Eldersburg Carroll If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Min. Months Hours 1 M 2 K Days 35 06 078 Sept 24 Director 1968 PA Usual Residence of Decedent es I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
If them 27 Is marked other then "neturel", or Items 23a or 28e-f show in other traumatic event, the Maryland Examinator use the mailford at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Md Carrol1 Eldersburg Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6780 McBeth Way 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ 1 If Yes, Give X Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) hair care beautician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gallen Weaver Joyce Groves ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Don D. Wooden Jr. (spouse) 6780 McBeth Way, Eldersburg, MS 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ± ŏ permit. Page Department o Importent: If eny injury or once. Sykesville, Md All County Cremation 17-5-04 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year jo Day 4□Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2X No 1 🗌 Yes 1 Yes 2□No To the Hospitel or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 2 5X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home this 28d. escribe how injury occurred 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending investigation 1 🔲 Yes 2 No

Division of Vital

fo the within 24 hours the Funeral D'

death.

Director:

D

State Registrar

Medical

Month, Day, Year)

2004

6 ☐ Could not be

determined

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature an

32. Registrar's Signature

and manner stated

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Greane

29d. Date signed (Month, Day, Year)

Balt,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			State of Maryland /			ental Hygier	ie	
			1 - State Registrar	Certificate of L	Death	Reg. N	enni.	21111
	Physic	cian	1. Decedent's Name (First, Middle, Last)				Day Year	C-3. Time of Death
	/Med	lical	Edward Carl Wilson	4.0: 7			3 2004	1040AM
	Exam	iner	4a. Facility Name (If not institution, give street and number)	0	Location of Death	'	c. County of Death	ı
	Funera		Mariner Health of Belair  5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthp	lace (State or Foreign try)
	Directo		219-22-6910 <b>X</b> XM 2□ F 76	Yrs. Months Days	Hours Min.	Month, Day, Yea July 7, 19		Virginia
	pu ,		Usual Residence of Decedent					
	aryla shov	7		own or Location			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	ecto	Maryland Harford Dar	lington 10f. Zip Code		100.0	Citizen of What Cour	
	with	<u>o</u>			21024	109.		itiy:
	death with the Maryland ms 23a or 28a-f show	Funeral Director	1756 Glen Cove Road  11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hi If Yes, specify Cuba	21034 ispanic Origin? (Spe	cify Yes or No-	USA 14. Race - Americ	an Indian,
	after o		1 □ Never Married 2 ☑ Married  1 □ Yes, Give			Rican, etc.)	Black, White,	etc.
	21215-0036 ad within 72 hours aft giene. ar than "natural", or the wedical Exam.	d by	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 🖾 No	Specify:		Specify: V	Mite
	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	Give kind of work done of	during most of working	ng 16b.	Kind of Business/Inc	dustry
	121 within than	mp	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired	•	Cla	M	-4
	Hygie	ပိ	17. Father's Name (First, Middle, Last)	Warehouse Worl		(First, Middle, Maid	oe Manufac <sub>en Sumame)</sub>	curer
	an id be ental ked c	To B	John Marvin Wilson	İ	Vera Ca	aroline I	Poole	
	Maryland Id 2 should be file Ith and Mental Hy Ith and marked oth	-		9b. Mailing Address (Street a				Code)
	and 2		Retha Wilson / Wife	1756 Glen Co	ve Road, I	Darlington	n, Marylar	nd 21034
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental thygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumetic event, the Medical Expirating must be notified at		20a. Method of Disposition 1 □ 8urial / 2 □ Cremation 3 □ Removal from State	of Disposition (Name of stery, crematory or other place	(e)	ate 20c.	Location - City or To	wn, State
,	Fag ment ment tant:		3/-	Grove Baptist		-04 Bel	Air, Mar	yland
İ	Ball permit Depart Import		21. Signat 11 m fal Service Ucensee	22. Name and Addres	uneral Hor	me, P.A.		
	- au		23a. Part1: Enter the disease, or complications that caused the death. D	1317 Coke	sbury Road	d, Abingdo	on, MD 210	009 Approximate
			shock, or heart failure. List only one cause on each line.	1	-			Interval Between Onset and Death
•	Physiciar /Medica		disease or condition resulting in death)		eurn	· C~	/	2 hours
-	Examine		Due to (or as a consequence	æ or):				
ch		Je.	Sequentially list conditions, if any, leading to immediate any, leading to immediate any, leading to immediate any leads to immediate any leads to immediate any leads to immediate any leads to immediate any leads to immediate any leads to immediate any leads to immediate any leads to immediate any leads to immediate any leads to immediate any leads to immediate any leads to immediate any leads to immediate any leading to immediate any leading to immediate any leading to immediate any leading to immediate any leading to immediate any leading to immediate any leading to immediate any leading to immediate any leading to immediate any leading to immediate any leading to immediate any leading to immediate and leads to immediate and leads to immediate and leads to immediate and leading to immediate and leads to immediate any leads to immediate and leads to immediate	>e of):				
100	cuted cuted	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events c					
	e exe	EX	resulting in death) Last Due to (or as a consequence	⇔ of):				
Q	s8760, icate be executed physician and s the burial-transit	dical	d					
	x 6 Sertific		IF FEMALE: 23c. If yes, outcome of pregnancy				22d Date of deliver	
3	O. Box 68  The death certific  The attending pl  Ched for use as t	Physician/M	in the past 12 months?	ath 3 Ectopic pregnancy	,		23d. Date of delive Month	Day Year
0	the dachee	hysi	1 Yes 2 No 9 Unknown 9 Unknown					
$\omega$	ecords, P.O. I law requires that the de as been signed by the a 2 should be detached to	by P	Part II. Dther significant conditions contributing to death but not resulting			23e. Did tobacco	o use contribute to the	e cause of death?
	cord: w require been sig		Afteroscleroke Corche	ovosculer	diserse	1 ☐ Yes	2 No 3 □ Prob	ably 4 □Unknown
-	of Vital Records Physician: The law requires r this certificate has been sigr	Completed				24a. Was an autopsy	prior to cor	osy findings available inpletion of cause of
3	The The page	Con				performed?	death?	
J	Vital Re sician: The la certificate has rector, page 2	Be	25. Was case referred to medical examiner?	Oth	26. Place of Death	(Check only one)		
	Phys Phys this ral dir	P.	1 Inpatient 2 EH	Outpatient 3 DOA Othe	4 ZANUISING FION	ne 5 Residence	6 ☐ Other (Specify	")
	Attending Physician: Geath. setor: After this certificative the funeral director.	tion	27. Manner of Death  1 (Month, Day Year)  28. Date of Injury (Month, Day Year)	Injury Work	k? Yes 2 □ No	.oc. Describe now III	july occurred	
50	Division  I or Attending after death. Diractor: After	Ifica	3 Suicide 6 Could not be				and Number or Rura	l Route Number,
Nilson	S after s afte	Certification;	4 Homicide determined building, etc. (Specity)		(1)	City or Town, Sta	179)	
3	Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier (Check only (Ch	Ige, death occurred at the tim	ne, date and place, a	ind due to the cause	(s) and manner as st	ated.
-	the hin 24 tha F	Medical	one) and manner stated.	29c. License			·	
	7 wit 5	-	29b. Signature and title of certifier				Date signed (Month,	
	11/19		30. Name and address of parent who completed source of death (fig. 22)	a) (Type Print)		Ju	7	,
	47		30. Name and address of person who completed cause of death (Item 23	10602 So	with Afr	wood Res	1. BEZ A.	2004 ER 21014
	s	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,		<u></u>	pr.	
	Regis	trar	JUL 0 6 2004 Beneva &	Sporket				

DHMH 17 Rev 1/2001

			1 - For State RegistramEND ITEM #2	State of Marylar OB PER FH G83	nd / Depa 33 7/06	artment of H 104 JH tilicate of L	ealth and N Death	Mental Hy	giene Reg. Ne? () ()	6 21115
			Decedent's Name (First, Middle, Last)			-		2. Date of De	eath	3. Time of Death
П	Physici		Florence Liebm	ann Zillig				July		Year 2004 11:00A M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County o	
	_ Admin	Ĭ	12401 Lime Kiln Ro	ad		Fulto	n		Howa	rd
- 1	Funeral		5. Social Security Number 6. Sec	x 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth	Birthplace (State or Foreign Country)
	Director		082-12-3006	M 2 <b>⊠</b> F 8	3 Yrs.	MOITINS Days	TIOUIS WIII.		1, 1921	New York
	pu ,		Usual Residence of Decedent	100 6	t. Town or lo					10d Inside City I imite
	urylar show	_	10a. State 10b. County		ty, Town or Lo	cation				10d. Inside City Limits
	Ba-f	cto	Maryland Prince Ge	orges si	lver S				- <del></del>	1 ☐ Yes 2 No
	or 2	Director	10e. Street and Number	_		10f. Zip Code			10g. Citizen of Wi	,
	ath w	ral	11815 Selfridge R			2090			United	
	tems	Funeral	T. Maria Sister	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)		- American Indian, , White, etc.
36	itled within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28e-f show with than "natural", or Items 23a or 28e-f show ent, the Medical Exement or constilled at	by F	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2☐No	Specify:		Specify:	White
21215-0036	hour tural	pe	15. Decedent's Edu		16a Dece	dent's Usual Occupa	ation		16b. Kind of Bus	iness/Industry
Ϋ́	in 72	Completed	(Specify only highest grad	le completed)	(Give	kind of work done of DO NOT use retired	during most of world	king		, in the same of t
7	with ene. than	m <sub>o</sub>	Elementary/Secondary (0-12)	College (1-4or 5+)	Admi	nistrativ	e Assist	ant	Civil Se	ervice Comm.
ס	Hyg Hyg other	O e	17. Father's Name (First, Middle, Last)		1 KAITIAL	ILDGEACLY			, Maiden Surname	)
an	ld be ental ked	To Be	Max Liebmann				Esther	Maclin		
Maryland	nd M mar	-	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	ng Address (Street a	and Number or Rui	rai Route Numb	er, City or Town, S	tate, Zip Code)
	nd 2 alth a 27 is r tree		Linda McKinney - D	aughter	9501	Dawn Blus	h Court	Columb	ia, Marvl	and 21045
ē,	s 1 a f Hea item othe		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of natory or other place	e) 7/07	<sup>D</sup> /04	20c. Location - C	City or Town, State
E	Page lent c nt: If ry or		1 XBurial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		dge Mem.		-	Elkrid	e, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show amy njury or other treumatic event, the Medical Examinate rules by notified at once.		21. Signature of Funeral Service Licens		22	. Name and Addres	s of Facility		9/	
m	P E E G		Mrsk, tay	cman	7	ary L. Ka 250 Washi	urman ru ngton Bl	neral H vd. El	ome At MM kridge. M	Maryland 21075
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the dea			-			Approximate Interval Between
	Physician		Immediate Cause (Final	( ca na	12170	Wear	Failur	di.		Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a prisec	quence of):	11 Car	Cortor	C		3 years
	Examiner			( )	Ohi	al Fibr	illation			542
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (ur as a consec	quence of):					7,
	cuted nd ransii	Examiner	Cause (Disease or injury that initiated events	. Covena	ry A	rterry 1	)ise ase	>		Zyeays
ó	an ar rial-t	EX	resulting in death) Last	Due to (or as a consec	quende of):	7				1
8760,	icate be executed physician and s the burial-transit	dical		d						
9	ng ph	Med	IF FEMALE:							
Вох	ith ce tendi	an/l	23b. Was decedent pregnant in the past 12 mogths?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23d. Date Mont	of delivery h Day Year
Н	e dea	Sici	1 ☐ Yes 2 ☑ No	4☐Pregnant at time of c 9☐Unknown	death 5	Other (specify)			Worth	n bay tour
<u>Р</u> .	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/Me	9 ☐ Unknown   Part II. Other significent conditions con	and have a second and have not see	outtiere in the	- db i	en in Deat I	22a Did	tobacca use contrib	oute to the cause of death?
	ires tha signed d be det	by			_	MECLIT				B ☐ Probably 4 ☐ Unknown
orc	w require been sign	ted			BE TES		00		163 242110 9	- Tiodabiy 4 Gonkilowii
ec	ne law nhas b ge 2 st	npie	WALDENSTROM	5 MACROC	110Bin	VEMIA		24a. Was auto	psy pri	ere autopsy findings available for to completion of cause of
H		Completed	CEREBRAL V	ASCULAR P	Accidi	ENT.		1 Tes	ormed? de	ath? ⊒Yes 2⊡No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	I		0.1	26. Place of Dea	th (Check only	one)	
7	d is	၉	1 192 5 7 140	Hospital: 1   Inpatient 2			4 Nursing H		idence 6 Other	
n o	ding F	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe	how injury occurred	d
sio	Attending ir death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	00 - Diversital as Auto			Yes 2 □ No	OOK Leasting (	(64	0 -10 - 11
Division of Vital Records,	or At	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ify)	eet, ractory, onice		City or To	wn, State)	r or Rural Route Number,
	pital purs a erel i		29a. Certifier 1 Certifying Phy	sician: To the best of my kne	owledge deat	h occurred at the tim	e date and place	and due to the	cauca(s) and man	nor as stated
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Exami	iner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my of	pinion, death occur	red at the time,	date and place, an	nd due to the cause(s)
	o the	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed	(Month, Day, Year)
	<b>⊢ ≯ ⊢</b> ŏ		Mel. o.	work A	an	03	1331		July	6 2004
	(1)		30. Name and address of person who co							0 2000
	10			HAUKAT,	1080	2 HICKE	DRY RIF	WE R	OAN COL	UMBIA MA
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign		111000	1-1 1011	100	-,10,000	21044
	Regist		JUL 0 6	2004 Seem	. H	South	4_			
DH	IMH 17 Rev 1/2	001	UVL V U	EUT JURIO	- , ,	The state of the s				

ORIGINAL

			1 - For State Registrar	State of	Marylan		artmen					giene Reg. No.		01116
			Decedent's Name (First, Middle	ə, Last)							2. Date of De	ath C	- 0 0 4	9. Time of Deat
	Physici /Medio		Vivian	Alice		Amb 1	er				June 1	Day 7 <b>.</b>	2004	4:35 P.M
	Examin		4a. Facility Name (If not institution	n, give street and numb	er)		4b. City,	Town, or	Location of	of Death			County of Dea	
			Anne Arundel M				Anna						Anne A	runde1
	Funeral		5. Social Security Number 235-32-9218	6. Sex 7. 1 ☐ M 2 💢 F	Age (In yrs. 79	last birthday, Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Bir	thplace (State or Foreign puntry)
	Director		Usual Residence of Decedent			115.					Apr. 1	. 192	25 Oh	io
	/land		10a. State 10b. County		10c. Cit	y, Town or L	ocation							10d. Inside City Limits
	Man a-f sh lifted	tor	Maryland Prince	Georges	В	owie								1 TXYes 2 □ No
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "naturel", or Items 23a or 28a-f show eumetic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 12212 Fox Hil	l Lane			10f. Zip	Code 2071	5				zen of What Co	puntry?
· _	fter deat	Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	12. Was Decede Armed Force ied 1 Tyes 2	es?	.S. 13.	Was Deced	ent of Hi	spanic Ori n, Mexican	gin? (Spe	ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit	
5-0036	hours a	by	3√Widowed 4 ☐ Divorced	It Yes, Give Year or Date	**		1 ☐ Yes		Specify:					hite
7	n 72 n "nat	Completed	15. Deceden (Specify only highes	st grade completed)		(Give	dent's Usua kind of wor DO NOT us	rk done a	turing most	t of worki	ng	16b. Kii	nd of Business	Industry
Maryland 2121	with liene.	шо	Elementary/Secondary (0-12)	College (1-4	or 5+)	E1eme				each	er	Edι	ıcation	
פ	ould be filed v Mental Hygie varked other t	Bec	17. Father's Name (First, Middle,	Last)		,			18. Mothe	r's Name	(First, Middle,	Maiden	Surname)	
Jar	uld by Menta Irked Itic e	To E	Alva Wi	se S	Stewar	t			Sara	ıh	Eliz	zabet	:h	Ice
ar)	2 should and Men is marke eumetic		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address	(Street a	ind Numbe	or Rura			Town, State, 2	Zip Code)
	is 1 and 2 should by Health and Men item 27 is marke other treumetic		Barbara Noonan/	Daughter		2216			rive,		- 4		ryland	
altimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from Sta	40	lace of Dispo	matory or of	ther place	9)	D	ate	20c. Lo	cation - City or	Town, State
Ħ	t. Partmen		`4 ☐ Donation 5 ☐ Other (S	pecify)	Lai	kemont					2004	Davi	ldsonvi	lle, MD
Ba	permit. Pages Department of Importent: If i eny Injury or once.		21. Signature of Funeral Service	There									ns Fune: eryland	ral Home 20715
п			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	sed the death h line.									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	dhu	17 16	9 ()	Uu	elou	10				Onset and Death
п	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of:		1	- 00					-
н		<u>_</u>	Sequentially list conditions, cause. Enter Underlying	b	as a consecu	i anni: mft-								
	ted nsit	Examiner	Cause (Disease or injury	505.00	ale o liverage.	annuo sury.								
	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):								
8760	ate be hysicia the buri	cail		d										
9	rtifica ng phi as th	0	15.551.11.5											
Box	eath certific attending p for use as	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birth			Ectopic pre	egnancy				2	3d. Date of del	*
o.	The law requires that the death certificate the has been signed by the attending phys age 2 should be detached for use as the	Physician/Me	1 Yes 2 No 9 Unknown	4□Pregnant 9□Unknown		eath 5	Other (spe	ecify)					Month	Day Year
ري ت	s that ined b e det	by PI	Part II. Other significant condition	ns contributing to death	h but not resu	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco us	se contribute to	the cause of death?
ecords,	w require been sig should b										1 🗆 Y	es 22	BKNo 3□Pr	obably 4 Unknown
ပ္သ	law requas been 2 should	Completed				_					24a. Was		24b. Were au	topsy findings available
ř	The lav	E O									autop perfor	mad? 2 2 No	death?	completion of cause of
Vital H	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			
0	Physicien: r this certific ral director,	2	1 ☐ Yes 2 No	Hospital:	atient 2 🗆 I	ER/Outpatier		400	4 🗀 Nul	rsing Hom	ne 5 ☐ Resid	ence 6	Other (Spec	city)
	ding P h. After t funera	lon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	9	njury Day Year)	28b. Time or Injury		Bc. Injury Work			8d. Describe h	ow injury	occurred	
Sic	Attendi death. ctor: A y the fu	icat	2 Accident investig	not be	Injuny At ho	mo form at	M		'es 2□N	_	Of Logotian (S	V	1 A/	- / Courte Africation
DIVISION	al or A	Certification;	4 ☐ Homicide determi	ined 28e. Place of building,	etc. (Specify	nie, iaim, str	eet, ractory,	, опісе			City or Tow		i Number or Hu	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical (	29a. Certifier Certifyin (Check only one)	g Physician: To the be Examiner: On the basis and manner	s of examinat	wledge, deatl ion and/or in	occurred a	at the time in my op	e, date and inion, deat	d place, a h occurre	nd due to the o d at the time, o	ause(s) a	and manner as place, and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	) /	1		29c.	License	number		2	29d. Date	signed (Manth	, Day, Year)
			> Veded(lo	X12 De [11]	, )			1) (	636	4		06	117/1	14
			10. Name and address of person	who completed cause of	death (Item	23a) (Type,	Print)	?	D	A	WAR	C 10 A	P15 (1)	01
寄り	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 1	2004 32 Aegi	strar's Signat	ure		3	00	V-) IV	WITTUC	n w	Y CIT	<u> </u>
	negistr	all			, Ju									

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** June 13, 10:43 A M 2004 Pauline Wanda Abell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 4, 1922 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 81 1 □ M 210 F Washington, DC 577-26-2733 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State 10b. County Show I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 shov other traumatic avent, the Medical Exemplian motal to profitted at 1X Yes 2 □ No MD Calvert Chesapeake Beach Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 3224 Chesapeake Beach Road 20732 USA Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Peges 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White þ 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Corrina Phillips ၉ Walter G. Knowlton 19a. Informant's Name/Relationship (Type, Print) -19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11009 Atwell Avenue Bowie, MD 20720 Robert M. Abell (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June Dato. 20a. Method of Disposition ō = 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any injury or once. 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD Lee Crematory 21. Signature of Fundal approach cen 22. Name and Address of Facility Lee Funeral Home Calvert, PA 8125 Southern Maryland Blvd Owings, MD 20736 Lee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Vertacular resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PLOUDARY Due to (or as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 2 Yes 2 No 3 Ectopic pregnancy Month Day Year õ 5 Other (specify) 4☐Pregnant at time of death P.O. the 9 Unknown detached 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 3 Probably 42 Unknown 1 ☐ Yes 2 ☐ No Completed 24b Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy has certificate 1 Yes 2 No 26. Place of Death (Check only one, 25. Was case referred to medical examiner? director, Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 2 ER/Outpatient 3 DOA Certification; To Sir. funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? After 5 Pending investigation Matural M 1 ☐ Yes 2 ☐ No death. 2 Accident the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide pelli Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only onel and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D17324 6/15/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Cox Road, Huntingtown, MD 5 -20639 aymon 31. Date filed (Month, Day, Year) 32. Registra State 2004 Registrar

lizabeth Bullard

1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Bullard Elizabeth Η. June 16, 2004 11:20PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kensington Nursing & Rehab. Ctr Kensington Montgomery 5. Social Security Number 86 6. Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) Delaware 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 21, 1921 **Funeral** 1□M 2XF 216-20-<del>1268-</del> Director Yrs. Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic avent, the Medical Examiner roust be notified at Directo Maryland Calvert Huntingtown 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 4955 Huntingtown Road 20639 USA "natural", or Itams 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene, Importent: If itam 27 is marked other than any injury or other traumatic avent. The Magnes. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Educator Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Holland Rov Edith Willis ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Wilfred Bullard/son 4955 Huntingtown Rd. Huntingtown, MD 20639 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Ward's UMC Cem. other place) 6/24/04 Owings, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Fred., MD20678 21. Signature of Funeral Service Licenses Gladys Q. ewell 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ADVANCED ALZHEIMER'S YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 2 signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed's certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 🖾 Hospital or Attanding Physicien: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident hours after death unaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide within 24 hours a To tha Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date, signed (Month, Day, Year) 009874 Coppeller 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARRAGUT AUE KENSINGTON, MD 20891 VARRY N. ROSENBAUM 3720 31. Date filed (Month, Day, Year) 32. Registras Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 5 per fb 9846 8-15-05 vt State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

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	show	J.	10a. State 10b. County		10c. City, Town or L						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
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9	or Ite	F	1 ☐ Never Married 2 ☐ Marr		No	1 ☐ Yes Z No		, Puerto Hican, etc.)		Black, White	
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r	, K		30. Name and address of person	who completed cause	of death (Item 23a) (Type	Print)	1	11	14.	2 , 7.	/ >
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Physician   Medical Examinor	Ω	88 58		Viabet (3	Cont	ten	415 I	last	Wilson Bl	Lvd., Ha	gerstown	ı, Mar	yland	<sup>d</sup> 21740
Madical Examiner    Madical Examiner   Madical Exam		Discourse of the second		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused ne cause on eech lin	the death. Do	o not enter the n	node of dy	ing, such as cardia	c or respiratory a	rrest,		Approxima Interval Be Onset and	ate etween d Death
Sequentially list conditions, if erry, leading to immediate cause. Enter the drying cause given in Part I.    Comparison of the cause of death of the cause	1	/Medical		Immediate Ceuse (Final disease or condition	ishor	wi	card	ไอทเ	unvortu	T.I			140	ar.
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Decretation of the cause of death of the cause of the cause of the cause of death of the cause of	928	cata be ohysici the bu	dica	trial initiated events	3	Due to (or es	e consequence d	of):						
1   Yes   2   No   3   Probably   4   Unknown   24a. Wes an autopsy performed?   24b. Were autopsy findings available prior to completion of cause of death?   1   Yes   2   No   1   Yes   2   No   No		E 0 66			d									
The part of the pa		death e atter id for t	sicial	Part II. Other significent conditions co	ntributing to death bu	ıt not resulting	in the underlyin	g cause g	iven in Part I.	23b. Did	tobacco use co	ntribute to	the cause	of death?
25. Was case referred to medical examiner?	P.0	d by th	Phys							1 🗆	Yes 2□ No	3 ☐ Prob	ably 4	Unknown
25. Was case referred to medical examiner?	cords,	requiras the	eted by							24a. Wes	an autopsy ormed?	ava	ilable prior	r to
25. Was case referred to medical examiner?	Re	he law e has age 2	dwo							12.5	Yes X No			
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Dey, Year)		Afte fund	tion:	1 Naturel 5 Pending	(Month, Day	Year) 28b	Injury			28d. Describe	now injury occur	180		
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Dey, Year)	Division	or Attendata deat Director:	ertifica	3 ☐ Suicide 6 ☐ Could not be			farm, street, fac	tory, office				er or Rurel	Route Nui	mber,
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1 CANON & CURA DO STORE & 21 of		Vithin To the		29b. Signature and title of certifier	C1	,		29c. Licer	se number		29d. Date signe	d (Month, E	Dey, Year)	
30. Name end address of person who completed cause of death (Item 23e) (Type, Print)  MANZAIL 25 (+4 F) 368 mill Street Noise form MD 2740				Manyen	g sua	h		02	8365		6-2	1-04		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		DK		30. Name end address of person who c	ompleted cause of de	) /- C	**	Stor	rol- Ha	00-km.	[red	10 2	Ma	
State 31. Dete filed (Month, Pal) 1 2004 32. Redistrar's Signeture			te	31. Dete filed (Month, Plan Year) 1	004 32. Redistra	r's Signeture	1			Line	u , (	<i>V</i>	1,40	

DHMH 16 Rav 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year 7:30 A M John Richard Baltimore June 12 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 814 Dale Street Hagerstown Washington County 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) **Funeral** Days Hours 62 Yrs. 220-40-0140 **Director** April 6 1942 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or frams 23e or 28a-f show traumatic event, the Medical Examinar must be notified at Y Yes 2 □ No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 814 Dale Street 21740 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Printing Company 10 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any july or other traumatic event 900g. 18. Mother's Name (First, Middle, Maiden Surname) Be Cecil Baltimore Helen Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 814 Dale Street Hagerstown, Maryland Wanda Baltimore (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery June 16, 04 Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 aulei 23a. Pert1. Enter the disease, or complications that caused the death. Do not enler the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death azcinoma **Physician** month. au crosse /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the deriving Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit been signed by the attending physician and should be detached for use as the burial-tra resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2 No 1 Yes 1 ☐ Yes 2∏ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Matural 5 Pending ours after death. death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only one) 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) 6-15-2004 2145 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOUL W) 12821

DHMH 17 Rev 1/2001

State Registra

31. Date filed (Month, Day, Year)
JUN 17 2004

32. Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar #23a Part 1&2, per/physicia ceftificate of Death 6/21/04, Amended item 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** VIRGINIA LEE BARLAGE lune /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death Examiner REGIONAL Madical SALISBUR TENINSULA If Under 1 Year | If Under 24 H/s 6. Sex 8. Date of Birth (Month, Day, Year) 2/10/1935 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2 X Months Days Hours 214-32-0740 Yrs Director 69 343-22-9848 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location wouls. treumetic event, the Medical Examiner must be nutified at Director Worcester Pocomoke City 28a-f 10e, Street and Number 10f. Zip Code ō 21851 or Items 23a 17 Clarke Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2 **X**No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify: þ 3 XWidowed 4 □ Divorced natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BARIAGE Comple Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 other Uth and Mental Hw 17. Father's Name (First, Middle, Last) Be George Lee Taylor 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a. Importent: If item 27 is any injury or other treu once. Teresa Brittingham (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State First Baptist Cemetery `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mura 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Stevens - Johnson /Medical Due to (or as a consequence of): **Examiner** torick Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No ō 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by Steven-Johnson syndrome Be Completed Vital or Attending Physicien: 25. Was case referred to medical examiner? Hospital: To 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 5 Pending 1 R Natural injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel L 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number

Specify: white 16b. Kind of Business/Industry Domestic 18. Mother's Name (First, Middle, Maiden Sumame) Grace Elizabeth Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2554 Lambertson Rd., Pocomoke City, MD 21851 20c. Location - City or Town, State 6/5/2004 Pocomoke City, MD 22. Name and Address of Facility
Holloway Melson Funeral Home, P.A.
103 Linden Ave., Pocomoke City, MD Approximate Interval Between Onset and Death Sundrome Pneumonia Metastatic merkel cell cancer to brain 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2晉No 26. Place of Death Check onl. one 1 2 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d, Date signed (Month, Day, Year) 140059368 30. Name and address of persop who completed cause of death (Item 23a) (Type, Print) 100 E CA11811 ST SALISBUIL

Rag. No. WCHD, EOT

Year

KINOMICO

Marvland

14. Race - American Indian, Black, White, etc.

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 □ No

2004

4c. County of Death

10g. Citizen of What Country?

USA

Registrar DHMH 17 Rev 1/2001

10

State

NOHN

31. Date filed (Month, Day, Year)

M.O.

32. Figistrar's Signature

1151061

JUN 2 1 2004

			1 - State of Maryland / Department of Health and Certificate of Death		giene	14 21123
	Physic	ian	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day	Year 3. Time of Death
	/Medi	cal	4a. Eacility Name (If not institution, give street and number)  4b. City, Town, or Location of Deal	June	19, 20 4c. County o	
	Examir	ner	Berlin Nusing and Rehab Center Berlin, N	1D	Word	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min			Birthplace (State or Foreign Country)
	Director		214-12-9546 1 Months Days Hours Min.	9-9-2	1	MD_
	/land		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e-feh	ctor	Md. Worcester Berlin			1 ☐ Yes 2.10 No
	or 28	Dire	10e. Street and Number 10f. Zip Code		10g. Citizen of Wi	hat Country?
	eath v	erai	11429 Gum Point Road 21811  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	S=	USA	Annice Indian
(0	r item	Funeral Director	Armed Forces? II Yes, specify Cuban, Mexican, Puèr 1 □ Never Married 25⊈ Married 1 □ Yes 2 ☑ No	to Rican, etc.)	Black	- American Indian, r, White, etc.
Alma 215-0036	ours a	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify:	White
Alma 15-003	n 72 h "natu	lete	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most of wo life. DO NDT use retired)	nking	16b. Kind of Bus	iness/Industry
_	filed within Hygiene. Ither than	omp	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker		Own Ho	ome
ler nd (		Be Completed		me (First, Middle,	Maiden Sumame	)
naç ylai	ould be Mental Marked c	To		. Dorsc		
Bohager, Maryland 2	C/ @		19a. Informant's Name/Relationship (Type, Print)  William T Bohager Son 11429 Gum Point Rd		•	
	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. once.		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		City or Town, State
altimore,	nit. Pages artment of ortent: If it injury or o		1 □ Burial 2 ☐ Cemetary or other place)  1 □ Burial 2 ☐ Cemetary crematory or other place)  Salisbury Crematory	6-20	Salish	bury, Md.
alti	Departir Departir Importe eny inju		21. Signature of Furnital Service Licens 22. Name and Address of Facility			J. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.
<u> </u>	20529		23a.Cearl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia.		Berlin,	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	c or respiratory arr	631,	Approximate Interval Between Onset and Death
3760,	death certificate be executed e attending physician and of for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			
.O. Box 68	death certific e attending p od for use as t	hysician/Med	FFEMALE:   23b. Was decedent pregnant   1		23d. Date Monti	
rds, P.	The law requires that the to have seen signed by the bage 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Malignart pieural ethesion			oute to the cause of death?
Division of Vital Records,		e Completed	Chonic obstrictive primurary dilla Congestive heart failure	1 Yes	med? dea	ere autopsy findings available or to completion of cause of ath?  Yes 2  No
Ξ	S 0 5	To Be	examiner?  1  Yes 2  ZH0	ath Check only on	ence 6 □Other	(Specify)
-0	ding Phys h. After this funeral di		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury Work?		ow injury occurred	
siol	lendir eath. or: Al	catic	2 Accident Investigation M 1 Yes 2 No			
Divi	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Attercompletely filled in by the funer	Certification:	4 Homicide determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)	City or Town	n, State)	or Rural Route Number,
	Host 24 hol Fune stely fi	edical	29a. Certifier  (Chast winy one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place control of the basis of examination and/or investigation.	a, and due to the caurred at the time, d	ause(s) and mann ate and place, and	ner as stated. d due to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier 29c. License number (	F) 2	9d. Date signed (	(Month, Day, Year)
			I sustine suffer, us a-00067	95	6-20	1-04
	C-M		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Malle	AL F	7.111111
	Sta	te.	31. Date liled (Month, Day, Year)  32. Refistrar's Signature  33. Refistrar's Signature	AND	THE	19944
	Registr		31. Date liled (Month, Day, Year)  JUN 2 2 2004  32. Refistrar's Signature	,,, ,,,	1	•

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** Clarence Commodore, Jr. June  $2\overset{\text{Day}}{0}$ . 2004 3:30P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1001 Sixes Road Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F 217-34-0014 67 Yrs Director Feb.6,1937 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic evant, the Medical Exament must be notified all 10d. Inside City Limits Prince Frederick 1 ☐ Yes 2 No Maryland Director Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20678 USA 1001 Sixes Road desth v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: à 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If itam 27 is marked other tha any injury or other traumatic event, Ins. 2008. Backhoe Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Commodore, Sr. Henrietta Boots Clarence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mazie C. Commodore/wife 1001 Sixes Rd. Prince Frederick, MD 20678 20b. Place of Disposition (Name of cametery, crematory or other place)
Patuxent UMC Cem. 6/26/04 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Huntingtown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home Gladys 1451 Dares Beach Rd. Prince Fred., MD2067 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Idenocarcinona /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 PYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has certificate 2 1 No 1 🗆 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 2 this After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 PNatural 5 Pending investigation within 24 hours after death. To tha Funaral Diractor: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Chack only one) tha 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 6-21-04 016823 30. Name and address of person who completed rause of death (Item 23a) (Type, Print) Robert J. Schlager, M.D. Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registres Signature State 2 2D04 Registrar

			1 - For State Registrar	State of Maryland	/ Depa	artment of H	lealth and M	lental Hyg	iene	04	21125
			1. Decedent's Name (First, Middle, La	ist)				2. Date of Deat			3. Time of Death
	Physici /Medi		Ella Mae	Catterto	on			June 19	, 2004	Year	4:50 p <sup>M</sup>
Fi.	Examir		4a. Fecility Name (If not institution, given	re street and number)		4b. City, Town, or	Location of Death		4c. County	of Deeth	<u> </u>
			Anne Arundel Medi	cal Center		Annap	$\infty$ lis		Anne	Arun	del
4.	Funeral			Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birthp	lace (State or Foreign try)
	Director		212-30-0110	<sup>1□M 2</sup> XF 89	Yrs.	World Days	110013	Feb. 2,	1915	Mary	land
	pug M		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Lo	antine				Ta	
	sho	7	Maryland Anne Ar			Cation				110	0d. Inside City Limits
	he N	ect	10e. Street and Number	under .	Riva						1 ☐ Yes 2 No
	with	ä	385 Spring Cove	Poad		10f. Zip Code 21140		10	g. Citizen of		try?
	eath	era	11. Marital Status	12. Was Decedent Ever in U.S	12			-4.4	U.S.2		
10	ter d	5	1 ☐ Never Married 2 ☐ Married	Armed Forces?	. 13.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		ce - America ck, White, e	
036	urs a	by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2∏No	Specify:		Specif	<sup>y:</sup> wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show its Modical Exeminat he notified at	Completed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ation		6b. Kind of B		
218	thin 7	ple	(Specify only highest gri	College (1-4or 5+)	(Give life.	kind of work done of DO NOT use retired,	furing most of worki )	ing			,
2	od wil	Son	9		farm	er			agricu.	lture	
p	al Hy	Be (	17. Father's Name (First, Middle, Last				18. Mother's Name	(First, Middle, M	laiden Suman	10)	
yla	Ment Ment arke	ို	Merton Eldri		s		Annie		Griers	son	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a -f show any injury or other traumatic event, the Moulcal Exprainer must be notified at ances.	6 19	19a. Informant's Name/Relationship (			ng Address (Street a				State, Zip	Code)
	and lealth m 27	1	Shirley N. Norfol			Spring Co			21140		
ore	Jes 1 I of H If Ite or oth		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐	1 000	ce of Dispo n <i>etery, cren</i>	sition (Name of natory or other place	9)	ate 2	0c. Location -	City or Tov	wn, State
Ē	men tant: tury	1	' 4 ☐ Donation 5 ☐ Other (Specif	y) Frie	ndshi	p UMC Cem	etery 06/	23/04	riends	ship,	MD
Baltimore,	Deparition Department Importment		21. Signature of Funeral Service Licer	1588		. Name and Addres	•				
	403 a d		William K	· gro	R	ausch Fun	eral Home	P.A.,	wings,	MD 2	20736
8			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. one cause — each line.	Do not ente	er the mode of dying	, such as cardiac o	r respiratory arre	st,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a Conge	01	ve De	eart.	tail	ine		Onset and Death
1	/Medical Examiner		Tooling in addition	the to (or as a conseque	nce of)	1	1.				
		-	Sequentially list conditions, if any, leading to immediate	b. Dual in as a conseque	nce of):	10211	anov	<u> </u>			
	nsit	n In	Cause (Disease or injury	Prouv	2-60	1.0					
	s be executed siclen and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseque	nce of):					-	17
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9	ificat g phy as th			u.							
ŏ	death certifical e attending phy of for use as th	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand	у				23d. Dat	e of deliver	v
<u>m</u>	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal d 4 Pregnant at time of dea		Ectopic pregnancy Other (specify)			Mo		Day Year
o.		hys	9 Unknown	9□ Unknown							
ŝ	requires that the de reen signed by the a hould be detached f	by Physician/Med	Part II. Other significant conditions of	ontributing to death but not resulti	ng in the un	nderlying cause give	n in Part I.	23e. Did toba	icco use conti	ribute to the	cause of death?
Record	w require been sig							1 ☐ Yes	2-1 No	3 Proba	bly 4 □Unknown
S	> D 10	Completed						24a. Was an	24b. V	Vere autop:	sy findings available
	0 - 0	E O						autopsy perform		rior to com leath?	pletion of cause of
	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Death			☐ Yes 2	: [ No
	d is	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2□EF	VOutpatient	Otho				er (Specify)	
o c	ding Ph h. After th funeral		27. Manner Ceath 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injury Work	at 2	8d. Describe how			
<u>0</u>	Attendir death. ctor: Af y the fu	atic	2 Accident investigation	1	пцогу		es 2 🗆 No				
Division	after death after death Director: , d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office	2	8f. Location (Stre	et and Numbe	er or Rural	Route Number,
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	e Hospital or Attending 124 hours after death. e Funeral Director: After letely filled in by the fune	cal	(Orioca orii) Z   Medical Cxall	ysician: To the best of my knowled inner: On the basis of examination and manner stated	edge, death	occurred at the time	e, date and place, a	nd due to the cau	se(s) and ma	nner as stat	ted.
	the spiral	Medical		and manner stated.							
	유후유		29b. Signature and little of certifier	(,-		29c. License			I. Date signed		
			/			,	3041	4	2//	1/2	004
	8		30. Name and address of persen who	completed cause of death (Item 2	3a) (Type, F 1	Print)	2 / 200	1	alis N	102	1401
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra Signatur	0			7 11 11 11 11	J		
	Registr:		JUN 2	3 700/1	H	Andle					

State of Maryland / Department of Health and Mental Hygiene

						Certificate o	f Death		Reg. No.	21106
•	Dhualai		1. Decedent's Neme (First, Middle, La	st)				2. Dete of De Month	eth CUUS	3. Time of Death
	Physici /Medic		Patsy Mae CHURCH	IEY				June	15,2001	4 5:35 au
	Examir		4a Fecility Neme (If not Institution, giv	e street end number)			4b. City, Town, or	Location of Deatl	4c. County of Dee	eth o
			608 Observatory					rstown		ngton
	Funeral Director		214-32-4664	ex 7. Age 7. Age 6	(In yrs. last bir	thday) If Under 1 Yea Months Day		8. Date of Bir (Month, Da Dec. 5	y, Year) C	rthplece (State or Foreign country) ryland
	and and		Usuel Residence of Decedent  10a. Stete 10b. County		10c. City, Tow	n or Location				10d. Inside City Limits
	Mary	ō	Maryland Hashins	ton	u.	agerstown				12∐ Yes 2 □ No
	the 28	ē	Maryland Washing  10e. Street end Number	LOII	п	10f. Zip Code	•		10g. Citizen of Whet C	Country?
	3a or	Funeral Director	608 Observatory I	rive		21	.742		U.S.A.	
	daath	era	11. Marital Stetus	12. Was Decedent E	ver in U,S.	13. Was Decedent o		Specify Yes or No		erican Indian,
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Pygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, it a Medical Evarrities must be notified alongs.	by	1 ☐ Never Married 2 ☐ Married 3 ∰ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:	0	1 ☐ Yes 2X N		rto Rican, etc.)	Black, Whi	white
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a	and and la ma		19a. Informent's Neme/Relationship (	Type, Print)	19b	. Meiling Address (Stre	et and Number or F	Rural Route Numb	er, City or Town, State,	Zip Code)
	end ealth n 27		Warren W. Churche	y - Son					stown, Md.	
ore	of H		20a. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐	Removal from State	20b. Place of cemeter	Disposition (Neme of y, crematory or other p	alace)	Date	20c. Location - City or	r Town, State
E	Pag ment: I		4 ☐ Donation 5 ☐ Other (Specific		Rest I	Haven Cemet	ery	6/18/04	Hagerstow	m, Maryland
Baltimore,	Departition Departition Importation and Injury Band In	N	21. Signature of Feneral Service Licer			22. Name and Add 415 E. Wi			Funeral Ho	
	SWANNE	П	23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications to t caused	the death. Do	not enter the mode of d	lying, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between
1 4	Physician /Medical Examiner	Jer.	Immediate Cause (Final disease or condition resulting in death)	a. P	me	10.1	CC			Onset and Death
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⋚	Physician: The lathis cartificata he	o Be	examiner?	Hospital:	t 2 ER/Ou	tpetient 3 DOA	26. Place of De Other: 4 ☐ Nursing	eath (Check only o	dence 6 □Other (Spe	o o if al
of Vital	Phys rathis	7.	27. Menner of Deeth	28a. Date of Injury	28b. 1	Time of 28c. In hours			how injury occurred	ecity)
on	ding h. After	育	1 Maturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) I		/ork? □Yes 2□No	13-11111		
Division	To the Hospital or Attending Phywithin 24 hours after death.  To the Funeral Director: After thi complataly filled in by the funeral	Certification:	3 Suicide 6 Could not be determined			rm, street, factory, office	ce	28f. Location (: City or Tou	Street and Number or Fi vn, State)	Rural Route Number,
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	within To the	Me	29b. Signature and title of certifier		1	29c. Lice	nse number		29d. Date signed (Mon	th, Dey, Year)
	02		M. I La		201	1	DULLE	12	Tuna	16 2004
	C		30. Neme and address of person who	completed cause of de	eth (item 23e)	(Type, Print)	-709		J WY W	10,000
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п	Physic	ian	1. Decedent's Name (First, Middle		h			2. Date of Death Month	Day Y	3. Time of Death
4	/Medi		Kathryn Mother  4a. Facility Name (If not institution)			4b. City, Town, or t	ocation of Death	May	20 200 4c. County of	
1	Exami	1er	Shady Grove Adv	•	,	Rockvil				jomery
	Funeral		5. Social Security Number		Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
	Director		224-32-7903	1 □ M 2 🛛 F	86 Yrs.	Months Days	Hours Min.	(Month, Day, 1) Aug. 5,		Texas
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	anting				
	sho	5								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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	with with	0	6098 Potomac La	nding Driv		22485		10,	USA	at Country:
	death ms 2;	era	11. Marital Status	12. Was Decede		Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe	ecify Yes or No-		American Indian,
9	or Ite		1 Never Married 2 Marri	ed 1 ☐ Yes 2 [ If Yes, Give	⊠No	if Yes, specify Cuban 1□ Yes 2⊠ No		Rican, etc.)	- 127	White, etc.
5-0036	77 hours after death with the Maryla "natural", or Items 23a or 28a-f shou officed Exertiting the motified at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Date	es:	TE Tes ZZAINO	Specify:		Specify: W	Mhite
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<b>q</b>	filed Hygid Sther ant, I	C	17. Father's Name (First, Middle, I	Last).			18. Mother's Name	(First, Middle, Ma		
Maryland	s 1 and 2 should be filed within I Health and Menta I Hygiene. item 27 Is marked other than "other traumatic event, I're Market	To Be	JAMES LEMUEL Lemuel Mothers	<b>MOTHERSHED</b> hed	)		Stella	Ferguson	ŕ	
ary	shou ind M mar umat	-	19a. Informant's Name/Relationsh		19b. Mailir	ng Address (Street an			City or Town, Sta	ite, Zip Code)
	alth a alth a 127 ls		Sharon Bryce	- Daughte	r 1618	Angus Cou	rt, Crof	ton, Mary	yland 21	.114
Baltimore,	permit. Pages 1 and 2: Department of Health ar Important: If item 27 Is any injury or other trau		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation	2 CD	20b. Place of Dispo cemetery, crei	natory or other place	,	ate 20	Oc. Location - Cit	y or Town, State
Ĕ	Page ment ant: I		'4 □Donation 5 □ Other (Sp		Nationa Memoria	ll Park	1	/2004 F	alls Chu	ırch, Va.
alt	permit. Departr Importu any inju		21. Signature of Funeral Service L	icensee	CC0439 2	2. Name and Address				Funeral Serv.
Ш	20E 50		mer IV	( tousa	116	21 Jeff.	Davis Hw	y., Frede	ericksbu	rg, Va.22401
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	_ a	Perforat Comp1 as a consequence of):	ea coron o	idi ing Co	TOHOSCOP	y with	Approximate Interval Between Onset and Death
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8760,	cate be execut ohysician and the burial-tran	E	resulting in death) Last	C. Due to for	25.2.0000000000000000000000000000000000		$ \wedge$	VI BY MEDICAL	EXAMINER	
687			resulting in death) Last		as a consequence of):		THE CHICH APP	ROVED BY MEDICAL	EXAMINER	
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.O. Box	the death certifice by the attending pt ached for use as the	hysician/Medica	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Due to (or d	me of pregnancy n 2 ∐ Fetal death 3 ⊑ t at time of death 5 ⊑	Ectopic pregnancy Other (specify)	JERTIFICATION APP	V PROVED BY MEDICAL	23d. Date of Month	f delivery Day Year
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Records, P.O.	The law requires that the death certificate has been signed by the attending I page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition	Due to (or d	me of pregnancy  2  Fetal death 3  at time of death 5   1	Ectopic pregnancy Other (specify)  nderlying cause given , Hyperter	oin Part I. S <b>ion</b>	23e. Did tobal 1  Yes 24a. Was an autopsy performe 1  Yes 2 Ja	23d. Date of Month	Day Year  te to the cause of death?  Probably 4 Unknown  e autopsy findings available to completion of cause of h?
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				State of Maryland				•	•	•
			1 - State Registrar		Cei	rtificate of	Death	Re 2, Date of Death	g. NO ) .	2   2 0
П	Physici		1. Decedent's Name (First, Middle, Last) Suzanne El	izabeth	De C	arre		June 18,		
)	/Medic Examin		4a. Facility Name (If not institution, give s				r Location of Death	J	4c. County of De	
			16405 Brandywine  5. Social Security Number 6. Sex		st birthday)	Brandy If Under 1 Year	Wine If Under 24 Hrs.	8. Date of Birth	Prince G	
	Funeral Director			M OFF	8 Yrs.	Months Days	Hours Min.	Aug. 19,	<sup>Year)</sup> 1925 Rh	Sirthplace (State or Foreign Country) ode Island
	anyland show d et	_	10a. State 10b. County	-	Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☒No
	the Ma	ecto	Maryland Prince Ge	orge's Brai	ndywir	10f. Zip Code		10	g. Citizen of What	
	th with	al Di	16405 Brandywine R	oad			613		U.S.A.	
99	should be filed within 72 hours after death with the Maryland nd Mental Hygiene.  marked other than "natural; or Items 23a or 28a-1 show imatic event, It a Modical Examiner must be notified at	by Funeral Director	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ØYes 2 □ No If Yes, Give Year or Dates: 1951—	72	Was Decedent of Hif Yes, specify Cub. 1 ☐ Yes 2 ☑ No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W Specify:	merican Indian, hite, etc. white
00	2 hours	ted b	15. Decedent's Educ	cation	16a, Dece	dent's Usual Occup	ation	. 1	6b. Kind of Busines	ss/Industry
1215	within 73 ane. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+) 5+	life.	kind of work done DO NOT use retire Officer	during most of work d)		.S. Navy	
Baltimore, Maryland 21215-0036	d be filed ental Hygi ked other c event, II	To Be Co	17. Father's Name (First, Middle, Last) Octave	DeCarre	1		18. Mother's Nam	e (First, Middle, M	aiden Sumame)	Sands
Mary	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en QDC2.	<b> </b>	19a. Informant's Name/Relationship (Type Joan E. Kratko, fr				and Number or Rui Brandywi		City or Town, State	a, Zip Code)
ore,	es 1 ar of Hea fitem ? r other		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ R	emoval from State	ace of Dispo metery, crer	osition (Name of matory or other plan	ce)		0c. Location - City	or Town, State
ltim.	t. Pag rtment rtant: I njury o		'4 □Donation 5 □Other (Specify)  21. Signature if Funeral Service Licens			ans Cemet	ery 06/21	/2004 C	heltenham	n. MD
Ba	Depared Important any in		21. Signatural Furieral Service Licens	Neeban				e P.A.,	Owings, M	1D 20736
	Physician		23a. Part1. Enter the disease, or complishock, or heartfailure. List only on Immediate Cause (Final disease or condition	cations that caused the death. e cause on each line.  cardio - res				or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):					2 years
	n =	ner	gequentally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque		ar moduse	4515			
	te be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	breast can  Due to (or as a consequence)						4 years
760,	ate be executed hysician and he burial-transit	cal	C	dementia						5 years
89	n certificat Inding phy use as th	/Med	IF FEMALE:	2a If you cuttorma of program	101					
.O. Box	ne death the atte	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 □ Yes = 2 ☑No 9 □ Unknown	3c. If yes, outcome of pregnand 1 Live birth 2 Fetal of the 2 Pregnant at time of dead of the 2 Unknown	death 3	Ectopic pregnancy Other (specify)	/		23d. Date of d Month	delivery Day Year
Д.	es that igned b	by	Part II. Dther significant conditions con		Iting in the u	nderlying cause giv	en in Part I.			to the cause of death?
Records,	v requii been s should	ompleted	obesity, hyp		1,7,000	ni o		24a. Was an		autopsy findings available
al Rec	The lay ate has page 2	O		ess, hyperg	TACE	ша		autopsy perform 1 Yes 2	ed? prior t death X No 1 □ Y	o completion of cause of
Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗙 No	ospital:	R/Outpatier	nt 3 DOA Ott	OF.	h <i>(Check only one</i> ome 5 <b>X</b> Resider	nce 6 Other (S	pecify)
on of	Attending Physic death. sector: After this by the funeral di	tlon: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	Wo		28d. Describe how		
Division		ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		reet, factory, office		28f. Location (Str. City or Town,		Rural Route Number,
	Hospit 24 hour Funera stely fills	ledical C	29a. Certifier 1X Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, deatl on and/or in	h occurred at the ti vestigation, in my o	me, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	t-		29c. Licens	e number	29	d. Date signed (Mo	nth, Day, Year)
			20 Name and	moleted cause of death /h	22a) /T	Da Print)	OI Doct	- OKEI	06/18/	2004 # ) n
(	0+1		30. Name and address of person who co	Ficitowsk	LI L	(1) L	VALDO	Rf. M	D 200	004
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrate Signate 32.004	J. K	book	•			

			For State Ragistrar	State of M		epartment of Certificate of		-	7111	14 21120
			Decedent's Name (First, Middle,	Last)		ortinoate of	Dealit	2. Date of De		3. Time of Death
	Physic /Medi		Catherine	Mary Dec	ker			Month	Day	Year 19:112 PM
	Exami		4a. Facility Name (If not institution,	give street and number		4b. City, Town,	or Location of De		4c. County	
		Н	PONINSULA REGIO	11110	CENTA		594/3641	e/		COMICO
	Funeral Director		215-16-8632	3. Sex 7. A 1 ☐ M 2 <b>X</b> ☐ F	ge (In yrs. last birtho	Months Days			v. Year)	9. Birthplace (State or Foreign Country) PA
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	with the Maryland a or 28e-f show	to	MD Worces	ter	Ocean					1 XYes 2 □ No
	ith the	Director	10e. Street and Number	, cei	Ocean	10f. Zip Code			10g. Citizen of W	/hat Country?
	23a c	ai D	214 Somerset S	St.		21842			US	,
5-0036	72 hours after death natural', or Items 23.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' d 1 Yes 2 N If Yes, Give Year or Dates:	?	13. Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 X No	ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		e American Indian, k, White, etc. White
5-0	72 hours "natural", idical Exa	eted	15. Decedent's (Specify only highest	Education grade completed)	16a. Do	ecedent's Usual Occu	pation	orking	16b. Kind of Bu	siness/Industry
2121		Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	e. DO NOT use retire	ed)	, orking		
7	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M.		17. Father's Name (First, Middle, La	iet)		eamstress	·		Sewing	
an	ld be ental ked o	To Be	(not available)	·			Stella	ame (First, Middle,	Maiden Sumame	e)
Maryland	shoul nd Me mark	F	19a. Informant's Name/Relationshi		19b. M	ailing Address (Street	1		or City or Town	State Zin Code)
	ges 1 and 2 should be filed within to fleath and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Mental fleath and the fleath and the fleath and the fleath and fleath a		Anthony Treviso	nno (Son)	1	Somerset				
J.e.	es 1 and of Health I item 27 r other tr		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other pla		Date		City or Town, State
Baltimore,	Pa ment: ury		1 ☐ Burial 2 <b>XXX</b> remation 3 '4 ☐ Donation 5 ☐ Other (Spe		l .	enlopen C		22-04	Frankfo	ord, DE
Salt	permit. Pag Department Important: I eny injury c		21. Signature of Funeral Service Li	censee 2	0	22. Name and Addre	ess of Facility	he Burb	age Fun	eral Home
ш	<u>a</u> □ = a		/ lagueline	J. 1)ah	Petty	108 Willia	m St.,	Berlin, M	aryland	21811
			23a. Part1. Enter the disease, or construction shock, or head ailure. List of	inplications that cause ity one cause on each li	the death. Do not ne.	enter the mode of dyi	ng, such as card	ac or respiratory ar	rest,	Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition resulting in death)	_a. 19+1	JUE /	UTIZA CEL	LEBRA	HEMO	RIZHAH	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	C.S. 1			- 1	1002
		6	Sequentially list conditions,	b. Due to (r as	a consequence of):	>(0,0)				
	uted Insit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 10 (11 23	a consequence on,					
Ć,	ficate be executed physician and sthe burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
68760,	icate be ex physician the buria	edicai		d						
99	rtifical ng ph as th		IE egywy e		12.72					
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ₺ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	у		23d. Date Mont	of delivery h Day Year
ص	that bed by deta		Part II. Other significant condition	contributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
of Vital Records,	quires n sign	Ω								Probably 4 Monknown
00	s been s	Completed						24a. Was a	n 24b We	ere autopsy findings available
Re	The lav	E						autops perfor	med? pri	or to completion of cause of ath?
ital	ilcien: Th certificate rector, pag	a)	25. Was case referred to medical		/		26. Place of De	1 ☐ Yes : eath (Check only on		Yes 2 No
_t	X Sign	ToB	examine? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 ER/Outpat	ient 3 DOA Oth		Home 5 ☐ Reside		(Specify)
n o	ding Ph h. After th funeral	on:	27. Manner Death 1 Patural 5 ☐ Pending	28a. Date of Inju (Month, Day	Year) 28b. Time				ow injury occurred	
sio	r Attendi er death. rector: A by the fu	cati	2 Accident investigat 3 Suicide 6 Could not	be		M 1 🗆	Yes 2 □ No			
Division	or Attendated after death	Certification:	4 Homicide determine	28e. Place of Inju- building, etc	ury · At home, farm, c. (Specify)	street, factory, office		28f. Location (St City or Town	reet and Number n, State)	or Rural Route Number,
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.		29a. Certifier 1. ★ Certifying (Check only 2 Medical Ex	Physician: To the best	of my knowledge, de	ath occurred at the tin	ne, date and plac	e, and due to the ca	ause(s) and manr	ner as stated.
	To the H within 24 To the F complete	fedicai	one)	aminer: On the basis of and manner sta	examination and/or	investigation, in my o	pinion, death occ	urred at the time, da	ate and place, an	d due to the cause(s)
)	with To	2	29b. Signature and fittle of certifier	1		29c. Licens	e number 19432	2	9d. Date signed (	Month, Day, Year)
7 . F	t. 10		30. Name and address of person wh	completed cause of de	eath (Item 23a) (Typ	e Print)		ite A-102	1011	/
	Sta	e	31. Dafe filed (Month, Day, Year)	32. <b>f</b> gistra	JOU KIV r's Signature	perly	IR. Du	1+8/4-102	Jalish	ury MD 21801
	Registra		JUN 21	2004 Desce	w K A	parti				
DHM	MH 17 Rev 1/20	01		7-00						

ORIGINAL

Catherine Decker 215-16-8632

d / Department of Health Certificate of Death	h Re	ene g. No <sup>2</sup> () () () () () () () () ()
Davis  4b. City, Town, or Location	2. Date of Death Month March	01, 2004 5:02 P
Owings Mill	Ls	4c. County of Death Baltimore
Yrs. Months Days Hours		year) 9. Birthplace (State or Foreign Country) Maryland
Town or Location Owings Mills		10d. Inside City Limit
10f. Zip Code 21117	100	g. Citizen of What Country? USA
<ol> <li>S. Uas Decedent of Hispanic Or If Yes, specify Cuban, Mexica</li> <li>1 ☐ Yes  No Specify.</li> </ol>		14. Race - American Indian, Black, White, etc. Specify: White
16a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired)	est of working	6b. Kind of Business/Industry
	ner's Name (First, Middle, Ma ina Uhler	none aiden Sumame)
19b. Mailing Address (Street and Number 1115 Old Westminste	ber or Rural Route Number, (	City or Town, State, Zip Code) minster, MD 21157
nce of Disposition (Name of metary, crematory or other place) roll Cremation, Inc		oc. Location - City or Town, State  Campstead, MD
22. Name and Address of Facility 6028 Sykesy	ille Rd. Elde	n F.H. & Mon. Co.
etricture with complements of:  n  ence of):  ence of):  ence of):	lications	Interval Between Onset and Death
ey leath 3 Ectopic pregnancy tth 5 Other (specify)		23d. Date of delivery Month Day Year
ing in the underlying cause given in Part I.		co use contribute to the cause of death?
ion	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
0.1	1 ☐ Yes 2€ e of Death (Check only one)	KNo 1 ☐ Yes 2 ☐ No
8b. Time of Injury Work? nknown M 1 Yes 2XI e, farm, street, factory, office	28d. Describe how in No Ingested (	Caustic substance It and Number or Rural Route Number, Italians
edge, death occurred at the time, date and n and/or investigation, in my opinion, deat	nd place, and due to the causath occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	A E	Date signed (Month, Day, Year) -issued me 29, 2004
3а) (Туре,	29c. License number O • C • N	29c. License number O.C.M.E.  Print)  Print)  Print Penr

			For State	State of Maryla		artment of F			0001	01101
			1 - State Registrar		Cer	unicate of	Deam	2. Date of Deal	eg. No. [] []	21131
	Physici	an	Decedent's Name (First, Middle, Last)					Month	Day Ye	1 - 20 11
	/Medic				Estep			June	18 2004	
	Examin	er	4a. Facility Name (If not institution, give s				r Location of Death	1	4c. County of E	
			50 East Bay Front 5. Social Security Number 6. Sex		s. last birthday)	Deale If Under 1 Year		8 Date of Birth		Arundel
	Funeral Director			M 2 <b>X</b> F 63	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) June 19	Year) 9, 1940	Birthplace (State or Foreign Country) Marvland
			Usual Residence of Decedent	05				Duile 1.	7740	rarytand
	yland		10a. State 10b. County	10c. (	City, Town or Lo	cation				10d. Inside City Limits
	a-fs	ţō	MD Anne Ar	rundel		Deale	2			1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	t Country?
	th wi	al	50 East Bay Front	Road		20751			USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. \	Was Decedent of H f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		American Indian, Vhite, etc.
36	or It	by Fu	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 X No If Yes, Give		I ☐ Yes 2 🔀 No	Specify:		Specify:	white
21215-0036	i within 72 hours after death with the Maryland liene. r then "natural", or items 23a or 28a-f show the Medical Evaninar must be notified at	d be	15. Decedent's Edu	Year or Dates:	16a Deced	dent's Usual Occup	nation		16b. Kind of Busine	
<del>1</del> 5	n 72 n "na edic	Completed	(Specify only highest grade	e completed)	(Give	kind of work done DO NOT use retire	during most of world)	king	TOD. KING OF BUSINE	essindustry
12	within lene. than	шо	Elementary/Secondary (0-12)	College (1-4or 5+)		etary			state hi	ghway admin.
		0	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, I		
a	ould be Mental arked o	.o.	Thomas Nutwell	l Prout			Katie	Belle	e Phi	pps
Maryland	de de la		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street	and Number or Ru	ral Route Number	, City or Town, Star	te, Zip Code)
	1 and 2 Health a tem 27 is		Jackie L. Estep, s	spouse	50 E	East Bay	Front Roa	ad, Deale	e, MD 20	751
Baltimore,	Se to to		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R		<ul> <li>Place of Dispo cemetery, cren</li> </ul>	sition (Name of natory or other pla	сө)	Date	20c. Location - City	or Town, State
Ĕ	permit. Pages Department of I Important: If it any injury or o		4 □ Donation 5 □ Other (Specify)	S	o. Memo:	rial Gard	dens   06-2	2-2004	Dunkirk,	MD 20754
alt	Departi Departi Import any inj once.		21. Signature of Fugeral Service Cleens	9		. Name and Addre				
_	90 F # 9		William K	flor			neral Hom	· · · · · · · · · · · · · · · · · · ·		MD 20736
F			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused the de ne cause on each line.					est,	Approximate Interval Between Onset and Death
	Physician	7	Immediate Cause (Final disease or condition	Conge	thre 1	teurt	Failure	}		= 1~2 months
	/Medical Examiner		resulting in death)	Due to (or as cons		1 6	1/2			
	LAGIIIIICI	۰	Sequentially list conditions,	Due to (or as a cons	TC / My	orandi	opathu	)		years
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence or).	1 A	Pinehm			1404
	xecur and al-trar	xan	that initiated events resulting in death) Last	Due to (or as a cons	equence ou:	Adbert	CILION			gem
,160	death certificate be executed e attending physician and d for use as the burial-transit	calE		4						
687	ficate p phys is the									
Вох	death certific attending pl	N/W	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of preg		ne			23d. Date of	delivery
Ď.	death e atte d for	lcla	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify) _	y 		Month	Day Year
P.0	that the de led by the a detached	Physician/Med	9 🗆 Unknown	9∐ Unknown						
S,	The law requires that the site has been signed by the bage 2 should be detache	by F	Part II. Other significant conditions cor	A .	esulting in the u	nderlying cause gro	en in Part I.	23e. Did tob		te to the cause of death?
ord	v requir been si should		Adolal tibrille	ans				1 □ Y€	s 2 No 3	Probably 4 Unknown
Record	law r as be 2 sh	Completed	Morpid Obes	ity				24a. Was a autops	y prior	autopsy findings available to completion of cause of
<u> </u>		Con		,				perform	ned? death	
Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Lacatel.		10"		th (Check only on	Θ)	
of \	Phyai this c	ဥ	1 Yes Zano		☐ ER/Outpatien		4   Nursing H		ence 6 Other (5	Specify)
	ding F h. After funera	ion	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Woo	rk? Yes 2 □No	28d. Describe no	w injury occurred	
isi	e ta co	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home farm str		162 2 140	28f. Location (St	reet and Number of	r Rural Route Number.
Division	after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Spe	cify)	oot, lactory, office		City or Town		Transfer Todio Transcol,
_	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Phys	sician: To the best of my k	nowledge, death	occurred at the ti	me, date and place,	, and due to the ca	ause(s) and manne	r as stated.
	e Ho 24 h	edical	(Check only 2 Medical Examinate)	ner: On the basis of exami and manner stated.	nation and/or inv	vestigation, in my o	opinion, death occur	rred at the time, da	ate and place, and	due to the cause(s)
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Me	29b. Signature and title of certifier			29c. Licens			9d. Date signed (M	
			Gerald P.	Sterner,	M.D.	D	117245		June :	22, 2004
	d		30. Name and address of person who co	ompleted cause of death (It	em 23a) (Type,	Print)	0 2		, 2	
-	8		GERALD P. Ste	LRNER HI	) 190	hesai	seake R	Stach Re	1 Uwin	22, 2604 145 MD 20736
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registre's Sig 3004	nature #	Souls				

DHMH 17 Rev 1/2001

			For State Registrar	State	of Maryla	-	artment of F			Reg. N	1000	21132
	Physicia	an	1. Decedent's Name (First, Middle Mary Randolph						2. Date of Domestin JUNE 2		2004 2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution		umber)		4b. City, Town, o	r Location of Dear			c. County of Deat	12:35 P M
	LAGITITE	٠,	RAVENWOOD LUTHE	RAN VILLA	AGE		HAGERSTO	OWN			WASHINGT	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M <b>X</b> ☐ F		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, D	irth ay, Yea	9. Birt Co	hplace (State or Foreign untry)
	Director		579-10-3977 Usual Residence of Decedent		88	113.			July 1	Z, 1	915 Virg	inia
	nylan show	_	10a. State 10b. County		10c. C	city, Town or Lo	ocation		- · -			10d. Inside City Limits
	he Ma 28a-1 s	ecto	Maryland Washin	gton	Hag	erstown		<u></u>		10.0		1X Yes 2 □ No
	with Ba or	ī			•		10f. Zip Code				itizen of What Co	untry?
	death	nera	1023 Matthew CT 11. Marital Status		cedent Ever in	U.S. 13.	21740 Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S	Specify Yes or N	_USA ∘-	14. Race - Ame	
36	s after , or Ite	by Funeral Director	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	ed 1 🗆 Yes If Yes, G	2∭ No iive		1 ☐ Yes 2 ☐ No	Specify:	10 (110411, 610.)		Black, White Specify: Whi	
9	be filed within 72 hours after death with the Maryland ital Hygiene. of other than "natural", or flems 23a or 28a-f show event, the Modical Examinat must be notified at	ted t	15. Decedent	's Education		16a. Dece	dent's Usual Occup	ation		16b.	Kind of Business/	
215	ithin 7.	Completed	(Specify only highes Elementary/Secondary (0-12)		) (1-4or 5+)		kind of work done DO NOT use retired		rking			
7	iled Tygi Ther	Co	12 17. Father's Name (First, Middle, I	acti		Legal	Coordina		me (First, Middle		S. Gover	nment
and	2 should be f and Mental H Is marked of raumatic eve	To Be	Marshall Conard					Nellie		, ivialue	n Sumame)	
ary	2 should and Men Is marke aumatic	-	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address (Street	and Number or R	ural Route Numb	oer, City	or Town, State, Z	ip Code)
Σ,	es 1 and 2 should b of Health and Ments f Item 27 is marked r other traumatic e		Dr. Lawrence A.	Jones /	son		Unger Ro	d Smiths				
nore	Pages 1 nent of H int: If Ite iry or ot		20a. Method of Disposition  Burial 2 ☐ Cremation  Donation 5 ☐ Other (Sp.	3 Removal from	State	cemetery, crei	sition (Name of matory or other place	1	Date		Location - City or rryville	Town, State
Baltimore, Maryland 21215-0036	그 든 만 글		21. Signature of Funeral Service)		Gr		1 Cemeter  Name and Address		24,2004 st Haver	Vi Fu	rginia neral Ch	ane1
<u>~</u>	Departing any ir		15 7/1	<u> </u>								and 21742
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on a. <u>Gdv</u>	each line.	y'nom	er the mode of dyin		c or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Examiner			Due to	o (or as a conse	equence of):	U					
	₽ ≒	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to	(or as a conse	equence of):						
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a conse	equence of):				_		
68760,	ate be executed thysician and the burial-transit	icai E		4								
.89	rtificat ng phy s as th		IF FEMALE:									
Box	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregr	tal déath 3 [	Ectopic pregnancy			Į	23d. Date of deli-	very Day Year
	the de ached	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unki	nant at time of	death 5	Other (specify)					
	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	by Physician/Med	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying cause give	en in Part I.			_	the cause of death?
Ra	w requir been s should	eted									2 No 3 Pro	
Mary Rand	aician: The law scertificate has b lirector, page 2 s	Completed							24a. Was auto perfe		prior to c	opsy findings available ompletion of cause of
ital	ian: T	Be C	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes ath (Check only	-	o 1 Yes	2 □ No
~ >	Phyaician: rthis certific ral director,	2	examiner? 1 Tes 2 No		Inpatient 2	☐ ER/Outpatien		Nursing F	lome 5 ☐ Resi	idence	6 □Other (Spec	ify)
	ding P. h. After tunera	tion:	27. Magner of Death  1 Natural 5 Pending 2 Accident investig		of Injury oth, Day Year)	28b. Time of Injury	Worl	yat k? Yes 2 □ No	28d. Describe	how inj	ury occurred	
EBER. Division	il or Attending affer death. I Director: Affe d in by the fune	Certification:	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be 28e. Plac	e of Injury - At I	home, farm, str	eet, factory, office		28f. Location (	Street a	and Number or Ru	ral Route Number,
Ö	ital or rs afte ral Dir				ding, etc. (Spec				City or To		,	
	To the Hospital or Attending Phyaician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying (Check only 2 Medical is one)	xaminer: On the	e best of my kn basis of examin nner stated.	nowledge, death nation and/or in	n occurred at the time of the time of the contract of the cont	ne, date and place pinion, death occu	e, and due to the arred at the time,	cause( date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To th within To th compi	Me	29b. Signature and title of certifier	A 1.		-	29c. License			29d. D	ate signed (Month	, Day, Year)
			Manyon	J/sue	h		D2	8365		6	21-04	
	3H-3		30. Name and address of person of PAN 2 AR.	who completed cau	se of death (Ite	om 23a) (Type,	Print) UND Stv	el- NO	Crow tarm	, 14	12 21740	
2	Sta	te	31. Date filed (Month JUNY 27)	2 2000 32.1	Rigistrar's Sign	nature	Print) Will Stv		T	1		
	Registr	ar	3011 2	2004	Bein	1. A	oute					

	•	•	1 - For State Registrar	State of Ma		artmen				ental Hy	giene	2004	. 21	133
	Dhysisi	22	1. Decedent's Name (First, Middle, La							2. Date of De	eath Day	Yea	r	e of Death
	Physici /Medio		Peggy Lee E1			1			1	June	29	2004	00	0:05 <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, given				_	Location o	of Death		4c.	County of De		
	<b>F</b>			orial Hos	pital (In yrs. last birthda)		East 1 Year	If Under	24 Hrs.	8. Date of Bir	rth			te or Foreian
	Funeral Director			1 □ M 2 🗙 F	52 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Feb 6	195	2 Ma	aryla:	nte or Foreign
	pu ,		Usual Residence of Decedent		10c. City, Town or I									
	shov	'n	MD Lounty Kent		Millir									e City Limits Yes 2 ☐ No
	the N	ecto	10e. Street and Number		111111	10f. Zip	Code				10g Citiz	en of What	Country?	
	death with the Maryland ms 23e or 28e-f show r must be notified at	Ϊ́	210 S. Crane	St.			1651				U.S			
	death	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Deced	ent of His	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	o- 1		nerican India	٦,
9	after or Ite	/ Fu	1 Never Married 2 Married	1 Yes 2 No If Yes, Give Year or Dates:	0	1 ☐ Yes 2		Specify:		nicali, etc.)		Black, Wh	White	
orth 21215-0036	hours ural',	d by	3 ☐ Widowed 4 ☒ Divorced	1	100 Dec									
12 th	in 72 n "nat	olete	15. Decedent's E (Specify only highest gr	ade completed)	(Giv	edent's Usua e <i>kind of wor</i> DO NOT us	k done d e retired)	luring mos )	t of workin	ng	160. Kin	d of Busines	sylnaustry	
or   212	d with giene. ir thai	lmo	Elementary/Secondary (0-12) 11	College (1-4or 5+	•)	Homem	ake:	r			(	Own H	ome	
	al Hyg	To Be Completed	17. Father's Name (First, Middle, Las.	()						(First, Middle		,		
111 yla	ould b Ment arkec	2	James Powell							ce Wal				
Mar	12 sh h and 7 Is m rraum	1	19a. Informant's Name/Relationship			ling Address	•			I Route Numb				1
	1 and Health		Marla Ellswor  20a. Method of Disposition	th (daug	20b. Place of Disp	osition (Nam	e of			ate			or Town, State	
y nor	ages ant of it: If it y or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		Asbury				7/3,	/04			ton,	
Peggy L. Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic evant, the Medical Evantinat must be notified at ODGs.		21. Signature of Juneral Service Lice	$\sim$		22. Name and	d Addres	s of Facilit	у <sub>1</sub> ц	ome of	F C+.	- onhon	тс	ahaea
P <sub>e</sub>	Deg any any		1-11 (	Y	100510	18 We	st	Cros	s S	t. Gal	Lena	, MD.	2163	5
اء	Physician		23a. Inf. Enter ne disease, or con shock, or hand failure. List only Immediate Cluse (Final disease or andition resulting in death)	one cause on each line	the death. Do not e	nter the mode	of dying	g, such as	cardiac o	r respiratory a	rrest,		Onset a	mate Between nd Death
	/Medical Examiner		resulting in dealth)	Due to (or as a	consequence of):									
X		j.	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequence of):		-							
D	cate be executed obly siclan and the burial-transit	Examiner	cause, Enter Underlying Cause (Disease or injury that initiated events	C										
o,	an an rial-tr	Exa	resulting in death) Last		consequence of):									
8760	ate be hysici	licai		d										
9	as as	Mec	IF FEMALE:	23c. If yes, outcome o	f orogonanav									
O. Box	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	Physician/Medicai	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live birth 2 4 Pregnant at t	Fetal death 3	□Ectopic pre					2	3d. Date of d Month	elivery Day	Year
P.O	that the by the details		Part II. Other significant conditions	contributing to death but	t not resulting in the	underlying ca	use give	n in Part I.		23e. Did t	obacco us	e contribute	to the cause	of death?
rds	quires n sigr uld be	q p	Chronic Reml	Failure	Drabete	5	chi	me		10	Yes 2	No 3 1	Probably 4	□Unknown
00	law require as been si 2 should b	Completed by	a hetwettive	pulmone	m Risea	مد				24a. Was		24b. Were	autopsy findir	ngs available
Re	The la	E O			J						rmed?	death?	s 2 No	or cause of
ita	iician: The lav certificate has rector, page 2	Be C	25. Was case referred to medical examiner?						of Death	(Check only o				
of V	hysicathis call dire	၉	1 ☐ Yes 2 No		t 2 ER/Outpati			4 L 14u		ne 5□Resi			ecify)	
n o	ding Physician: n. After this certific funeral director,	lon	27. Manner of Death  1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury		3c. Injury Work	at ? ′es 2⊟I		28d. Describe	how injury	occurred		
Division of Vital Records,	death ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not I	De Blood of Injur	ry - At home, farm, s		-	93 2 🔲	-	28f. Location (	Street and	Number or I	Rural Route I	Number,
D N	after Dira	erti	4 Homicide determined	building, etc.	(Specify)	,				City or To	wn, State)			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) 12 Certifying P 2 Medical Exa	hysician: To the best of miner: On the basis of and manner stat	examination and/or	th occurred a nvestigation,	at the time in my op	e, date an inion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) a date and p	and manner a place, and du	as stated. ue to the cau	se(s)
_	To the To the Comp	W	29b. Signature and title a certifier	1		29c	License	number			- /	, /	nth, Day, Yea	ur)
			James 7	Moer "	~0	1	159	149			6/2	7/04		
	7			Oliver M.I	503	Cynv	rood	Dr.	Eas	ston,	MD.	2160	1	
	Sta	ate rar	31. Date filed (Month, Day, Year)	32. Registra	rs Signature				2					

DHMH 17 Rev 1/2001

ORIGINAL

	1- State of Maryla		artment of He tificate of De			ene g. No. O	
	Registrar  1. Decedent's Name (First, Middle, Last)				2. Date of Death	200	3 Time of Dealth
hysician	Robert Lewis Feik				Month June	Day Ye 20	004 1705
Medical caminer	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	ocation of Death		4c. County of E	Death
4	Anne Arundel Medical Center		Annapolis			Anne A	
eral ctor	5. Social Security Number 6. Sex 7. Age (In y. 485-12-2196 8	rs. last birthday) 5 Yrs.		Hours Min.	8. Date of Birth (Month, Day, Oct. 17	9. 1918	Birthplace (State or Fore Country) Illinois
	Usual Residence of Decedent						1011111001111
3	10a. State 10b. County 10c.	City, Town or Lo	cation				10d. Inside City Lim 1 ☐ Yes 2 📶
be notified Director	Maryland Anne Arundel A	nnapolis					100
Sire Sire	10e. Street and Number		10f. Zip Code			g. Citizen of Wha	
ra la	1324 Harmony Lane		21401			United S	tates American Indian,
eumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Maritat Status  1 Never Married 2 Married  12. Was Decedent Ever in Armed Forces?  1 Yes, 2 \( \subseteq \) No It yes, Give		Was Decedent of Hisp f Yes, specify Cuban, 1 ☐ Yes 2 No	Mexican, Puerto i Specify:	Rican, etc.)		White, etc.
ted by	3 Widowed 4 Divorced Year or Dates: WWL	16a. Deced	dent's Usual Occupation		1	6b. Kind of Busin	white ess/Industry
t, the Medical I	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done dui DO NOT use retired)	ring most of worki	ng		
- E	5+	Chi	ef Scient:	ist		Air Forc	e
e C	17. Father's Name (First, Middle, Last)		1	8. Mother's Name	(First, Middle, M	laiden Surname)	
To B	Lewis W. Feik			Tvo Mary	7 Teanhl	anc	
em	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street an	d Number or Rura	I Route Number,	City or Town, Sta	te, Zip Code)
r other treumatic	Mary Feik/ wife	1324	Harmony 1	Lane Anna	polis.	MD 21401	
otho	20a. Method of Disposition 200	b. Place of Dispo			ate 2	Oc. Location - City	y or Town, State
7 or	1 d Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	akwood C		June :	21, 2004	Dixon,	IL
any injury or of	21. Signature of Funeral Service Licensee						neral Home, s, MD 21401
	23a. Part1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.	Dell'				-	Approximate Interval Between
ion.	Immediate Cause (Final	Sho	oke				Onset and Death 2 days
ian ical	disease or condition resulting in death)  Due to (or as a constitution)		UNE				7 0(00/3
ner							
e e	Sequentially list conditions, it any leading to immediate Due to (or as a cons	sequence of):					
the burial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events						
Exa	resulting in death) Last Due to (or as a con-	sequence of):					
dical	d						
as the							
Itor use as clan/Mec	IF FEMALE: 23b. Was decedent pregnant 23c. tf yes, outcome of pre		Ectopic pregnancy			23d. Date o	
d لو ا			Other (specify)			Month	Day Year
detached to V Physici	9 Unknown 9 Unknown						
d be det	Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause given	in Part I.	23e. Did tob	acco use contribu	ite to the cause of death?
d bu					1 ☐ Ye	s 2 <b>X</b> No 3[	Probably 4 Unkno
page 2 should Completed					24a. Was ar		e autopsy findings availa
page 2:					autopsy perform	ned? dea	r to completion of cause : th? Yes 2□ No
o. p	25. Was case referred to medical			26. Place of Death			163 20 10
<b>6 6</b>	examiner? Hospital:	2 🗍 ER/Outpatier	Other		39: 840000	nce 6 Other (	(Specify)
ੂ  ⊢	27. Manner of Death 28a. Date of Injury	28b. Time o	f 28c, Injury a	at		w injury occurred	opacity)
fune ton	1 Matural 5 ☐ Pending (Month, Day Yea 2 ☐ Accident investigation	r) Injury	Work?	es 2 No			
led in by the funera	3 Suicide 6 Could not be 28e. Place of fnjury - /	At home, farm, st	reet, factory, office				or Rural Route Number,
completely filled in by Medical Certif	4 Homicide building, etc. (Sp	ecify)	•		City or Town	, State)	
	29a. Certifier (Check only (Ch						
Impletely fill	one) and manner stated.					9d. Date signed (A	
200			29c. License			6 15/1	
1	> Yourd Beck, My		<i>D</i> (	100>1		112/1	7
	30. Name and address of person who completed cause of death Signal August 2001 Media	(Item 23a) (Type.	way an	16052 napolis,	MD		
CA							
State gistrar	JUN 1 8 2004	ignature	front				

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month -125 A M **Physician** raley /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Maryland Worcester Berlin HOSPItal Atlantic Genera If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 100M 20F 227-12-0147 81 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Md. 1 Yes 2 □ No Worcester Ocean City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 904 Edgewater Ave. 21842 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1☑Yes 2 ☐ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 □ Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction 12 Mason 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) f Health and Mental Arlie Bias Jennings B. Fraley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Diana F. Brown/ Dgtr 1206 St. Louis Ave. #4 Ocean City, MD21842 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or 6 - 22 - 04Nat'l Mem. Park Falls Church, VA. \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Tuner Sarvice/Licenses 22. Name and Address of Facility Ullrich Funeral Home Berlin, Md. 23a. Part Enter the disease; or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition renal cell carcinoma metastatic Physician year resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consecuence of) Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? athoroscieratic 3 robably 4 □Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Obstructive autopsy performed? 1 Yes 2 14 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No jo 28a. Date of Injury (Month, Day Year) filled in by the funeral 28c. injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 Tyes 2 No investigation death. 2 Accident within 24 hours after deati To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number DE 29d. Date signed (Month, Day, Year) C1-0006795 30. Name and address of person who completed eause of death (Item 23a) (Type, Print) KRISTNE GRIFFIN, MD 1209 COASTAL HIGHWAY, FENUICK ISLAND, DE 19944 5+1 32. Segistrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 7 2004 Registrar

10-31-192

		For State Registrar  1. Decedent's Name (First, Middle, La	et)	Certificate	of Death	2, Date of Deat	eg. No 2004	2   36 3. Time of Death
Physicia	an					Month	Day Year	
/Medic	al	Donald Caden Ga 4a. Facility Name (If not institution, giv		4h City To	own, or Location of Death	June	18, 2004 4c. County of Dea	2:40 A <sup>M</sup>
Examin	er	Gilchrist Hospice		Towso			Baltimore	
<b></b>		-				8. Date of Birth		thplace (State or Foreign ountry)
Funeral Director		216-40-6984 Usual Residence of Decedent	7Z	60 Yrs. Months [	Days Hours Min.	8. Date of Birth (Month, Day, May 10,	1944 Was	ountry) Chington, D.C
land land		10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Items 23e or 28e-f show event, the Medical Examinar must be indiffied at	ctor	Maryland Howard	Co1	umbia				1 ☐ Yes 2X No
with th	Funeral Director	10e. Street and Number 11929 New Country	I.ane	10f. Zip C 2104			0g. Citizen of What Co USA	ountry?
ns 23	lera	11. Marital Status	12. Was Decedent Ever in U. Amed Forces?		nt of Hispanic Origin? (Spe y Cuban, Mexican, Puerto		14. Race - Ame	
after dea or Items	ם	1 Never Married 2 Married	tX☐Yes 2☐No			Rican, etc.)	Black, Whit	
urs a alf, o Exem	β	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1970	1 ☐ Yes 2 ☐	XNo Specify:		Specify. Whi	te
72 hours natural',	Completed	15. Decedent's E	ducation	16a. Decedent's Usual (	Occupation done during most of working	00	16b. Kind of Business	
hin 7	pie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use	retired)	rig		
gien gien grth	Ö	12	i	District Sa			Food Servi	ce
e file al Hy loth vent	Be (	17. Father's Name (First, Middle, Last	)		18. Mother's Name			
Menta Menta rked	To	Edward Joseph Gar	dner		Katherine	Elizab	eth Caden	
s ma		19a. Informant's Name/Relationship (	Турө, Print)	19b. Mailing Address (S	Street and Number or Rura	I Route Number,	City or Town, State,	Zip Code)
alth alth 27 i		Laurel K. Gardner	/ wife	11929 New C	ountry Lane	Columbi.	a, MD 2104	4
t territer other		20a. Method of Disposition	20b. F	Place of Disposition (Name emetery, crematory or other	of er place) June	21,	20c. Location · City or	Town, State
Page lent c nt: If ry or		1 ☐ Burial 2X☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special	Hemoval from State	Arundel Crem		-	Odenton, M	aryland
permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural any injury or other traumatic event, the Medical Exones.		21. Signature of Funeral Service Lice			Address of Facility Ome Crematio			
83188		Beverly L H	ette MO	1251 Beverly	L. Heckrott	e. P.A.	Clarksvil	
		23a. Part1. Enter the sease, or comshock, or heart failure. List only	eplications that caused the deat	h. Do not enter the mode	of dying, such as cardiac o	or respiratory arre	est,	Approximate Interval Between
Physician		Immediate Cause (Final		tatic v				Onset and Death
/Medical		disease or condition resulting in death)	a. Due to (or as a conseq		7(0 - 1)7(01			genu
Examiner								*U
- 4 3	Jer	Sequentially list conditions, if any, leading to immediate	b.  Due to (or as a conseq	uence of):				
te be executed ysician and ie burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Elect Underlying Cause (Disease or injury that initiated events	C					
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sicia e bur	cai		d					
uffica g ph) as th								
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		anancy.		23d. Date of de	•
deatl d for	icia	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Feta 4 Pregnant at time of d				Month	Day Year
ed by the detached	hys	9 Unknown	9□ Unknown					
es that igned b	by PI	Part II, Other significant conditions	contributing to death but not res	ulting in the underlying cau	ise given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
n sign	q p					1 ☐ Ye	s 2 Nio 3 □ Pi	robably 4 Unknown
been signal	Completed					24a. Was an	n 24b. Were a	utopsy findings available
has ge 2	m					autops	y prior to ned? death?	completion of cause of
n: Ti ficate r, pa		OF Was and information with a			00.00			2 No
ding Physician: The law h. Atter this certificate has b funeral director, page 2 s	Be c	25. Was case referred to medical examiner?	Hospital:	50/0	Other: 4 Nursing Hou			11/1-100
ding Phys	. To	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 2 28a. Date of Injury	ER/Outpatient 3 DOA 28b. Time of 28c	4 1 Nuising Ho	me 5 ☐ Reside	ince 6 <b>X</b> Other ( <i>Spe</i> low injury occurred	city) Hospice
ing After uner	ion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury M	Work? 1 □ Yes 2 □ No	_cc. poscilos no		
	Sal	2 Accident investigation 3 Suicide 6 Could not be	De Ole of Injury At h			28f Location (St	reet and Number or Ri	ural Route Number
tend leath tor: the	~	4 ☐ Homicide determined	building, etc. (Specif	ome, farm, street, factory, o	JIIIC8	City or Town		oral ribuid Number,
or Attendatifier death	ertific			wledge death occurred at	the time, date and place a	and due to the ca	ause(s) and manner as	s stated.
or Attendition fler death	Jical Certific	(Check only 2 Medical Exa	hysician: To the best of my kno miner: On the basis of examina and manner stated	tion and/or investigation, in	my opinion, death occurre	ed at the time, da	ate and place, and due	e to the cause(s)
or Attendatifier death	Medical Certification:	(Check only 2 Medical Example)  29h Signature and title of certifier	miner: On the basis of examina and manner stated.	tion and/or investigation, in	n my opinion, death occurre	29	9d. Date signed (Mont	h Day Year)
Hospital or Attend 4 hours after death Funeral Director: tely filled in by the	Medical Certific	(Check only 2 Medical Example)  29h Signature and title of certifier	miner: On the basis of examina and manner stated.	tion and/or investigation, in	n my opinion, death occurre	29	9d. Date signed (Mont	h Day Year)
or Attendatifier death	Medical Certific	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	tion and/or investigation, in	n my opinion, death occurre	29	9d. Date signed (Mont	h Day Year)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year Physician 3:35 P M 18 Ida B. Goodman June 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Spa Creek Genesis Elder Care Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 ☐ M 2 ☑ F Yrs. Director 87 April 17, 1917 North Carolina 212-34-5580 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count 28a-f show Examiner must be notified at 1 Yes 2 No Maryland Anne Arundel Annapolis Direct the 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 6 660 Americana Drive #11 21403 United States Itams 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygione. Important: If tiem 27 is marked other than "natural", or Ital eny injury or other traumatic event. The Madical Exemption ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white by 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Edgar Willis Alice Nickens ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carl Owens/ son 417 Duvall Lane Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State <sup>3</sup> 4 □ Donation 5 □ Other (Specify) Hillcrest Cemetery June 22, 2004 Annapolis, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licens John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 omercou 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician eeuel /Medical Due to (or as a consequence of): **Examiner** orna Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit attending physicien and Due to (or as a consequence of) Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ò in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death P.0. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, MILLE 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 26. Place of Death (Check only one, 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 💥 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide To the Hospitel 29a. Certifier 1 🛆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) e and title of certifie 29b. Signat 6-18-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADITYA CHOPEA,IMD 600 Ridgely Ave. Ste. 231 Annapolis, M.D. 2140 31. Date filed (Mont State 2 2004 Registrar

			1 ⊷ For State Registrar		Department of Health and Certificate of Death	d Mental Hygie	ene No2001	01100		
			1. Decedent's Name (First, Middle, Last)			2. Date of Death	-	9. Time of Death		
	Physici /Medi		Lillie	Bell	Givens	June	1 <sup>2</sup> 4 2004	10:00 A M		
	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of D	eath	4c. County of Death	1		
			17904 Barney Dr		Accokeek		Prince Geo			
	Funeral Director		5. Social Security Number 6. Security Number 261-20-5078	14 0XC	hday) If Under 1 Year If Under 24 H Months Days Hours M	September 1	Prince Georges  te of Birth parth, Day, Year)  nber 12,1918 Florida			
	land ow		10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits		
	a-f she	ctor	Maryland Prince Ge	orges Accoke	ek			Yes 2 No		
	or 28	Oire	10e. Street and Number		10f. Zip Code	_	Citizen of What Cou	intry?		
	ath w	ra	17904 Barney Drive		20607		USA			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, its Medical Examinat must be notified at ODGE.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt  1 ☐ Yes 2 ☒ No Specify:	(Specify Yes or No- uerto Rican, etc.)	14. Race - Ameri Black, White Specify: Bla	, etc.		
ဝှ	2 hou	ted	15. Decedent's Edu	cation 16a.	Decedent's Usual Occupation	161	o. Kind of Business/Ir	ndustry		
215	ithin 7 18.	Completed by	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of life. DO NOT use retired)	working	Domestic	,		
21	ygien ygien ner th	Con	12	He	omemaker					
Maryland 21215-0036	ould be fil Mental H arked oth atic even	To Be	17. Father's Name (First, Middle, Last) Unknown		18. Mother's P	Name (First, Middle, Mai	den Sumame) Williams			
Mar	ind 2 sho alth and 27 is m		19a. Informant's Name/Relationship (Ty) Harold Givens / So		Mailing Address (Street and Number or 904 Barney Dr. Acc					
Baltimore,	Pages 1 a nent of Hei int: If item iry or otha		20a. Method of Disposition  ¼ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State 20b. Place of cometen Resurre	Disposition (Name of v. crematory or other place) ection Cemetery 6/	Date 200 22/04 Cl	:. Location - City or T inton, Mai			
Balt	permit. Departri Imports any inju		21. Signature of Funeral Service License  Ociopoa Offer		22. Name and Address of Facility  Adams Funeral Home	e P.A. Aqua	sco, Maryl	land		
	Fnysician /Medical Examiner	her	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.  I any, leading to inmediate cause. Enter Underlying	cations that caused the death. Do not be cause on each line.  Duy to (or as a consequence of the consequence	acher	- A	°65°	Approximate Interval Between Onset and Death		
68760,	The law requires that the death certificate be executed attents been signed by the attending physician and page 2 should be detached for use as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence o	f):					
P.O. Box	the death certific y the attending pl ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver	ery Day Year		
rds, P.	quires that the de n signed by the a uld be detached f	þ	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	he cause of death?		
al Records,	yaician: The law requir is certificate has been si director, page 2 should I	Completed				24a. Was an autopsy performed 1 ☐ Yes 2 ☑	prior to co death?	psy findings available mpletion of cause of		
=	aiciar certif recto	o Be	25. Was case referred to medical examiner?	ospital:		leath (Check only one)				
Division of Vital	ding Ph h. After th funeral	-1	1  Yes 2 No	28a. Date of Injury 28b. Ti	me of ury M 28c. Injury at Work?  M 28c. Injury at Work?  1 Yes 2 No	Home 5 Residence 28d. Describe how in		(y)		
Divis	tal or Attano s after deati al Director: ed in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fam building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, St		ti Route Number,		
	To tha Hospital within 24 hours a To tha Funaral completely filled	Medical	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin	ician: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the time, date and pla for investigation, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)		
	To t Withi To til Comp	Σ	29b. Signature and title of certifier	Po,	29c. License number	- 1	Date signed (Month,	•		
			Wolldelhone in	Holiz	MD2569	89 61	16,200	7		
(	07		30. Name and address of person who cor	mpleted cause of death (Item 23a) (T	ype, Print)		> 0 0 -	- 0		
1	72		Abdolhossein Haf  31. Date filed (Month, Day, Year)	121 1328 South	urn Ave SE Ste 207	Washington	1, DC 200	32		
	Sta Registr	_	JUN 2 3 201	32. Egistrar's Signature	Sparke					

			1 - State Ragistrar AMEND ITEM	State of Man	Coss Ce	rtificate of	Death	i Mentai Hy		001	
			1. Decedent's Name (First, Middle, Last		6833 00	timoato or	Douth	2. Date of D	Rag. No.	<del>994</del>	3. Time of Death
	Physici			Verna Emm	a Graf			Month	Day	Year	0 05 - M
>	/Medi Examir		4a. Facility Name (If not institution, give		a Grar	4b. City, Town,	or Location of De	June 4		ounty of Death	2:25 A
			The Hermitage at	St Tohns	Crook	Colomon	C		Ca	lvert	
	Funeral		Social Security Number 6. Se	7. Age (II	yrs. last birthday)	Solomon If Under 1 Year	If Under 24 H		rth	9. Birth	place (State or Foreigi
	Director		156 26 2945	<sup>3 M 2</sup>	Yrs.	Months Days	Hours Mi	in. (Month, D Dec 9		Ponr	nsylvania
	D .		156 26 2945 Usual Residence of Decedent  10a. State 10b. County	146	c. City, Town or Le				1,00		
	shor	2									10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ith the Marylar or 28e-f show	ecto	Maryland Calvert		Solomons						
	with e or	Ö	13325 Dowell Road	1		10f. Zip Code 20688			-	n of What Cou ed Stat	•
	72 hours after death with the Maryland Inatural', or Items 23e or 28e-f show dical Examinar must be motified at	Funeral Director	11. Marital Status	12. Was Decedent Eve	r in U.S. 13			(Specify Yes or N		. Race - Ameri	
(0	riter	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Was Decedent of I If Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.)		Black, White,	
215-0036	al', o	by	3 □Widowed 4 □ Divorced	If Yes, Give A Year or Dates:		1 □ Yes 2√□ No	Specify:		S	∞eciwhite	<b>à</b>
2-0	72 hg natu	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occup	pation during most of w	vorkina		of Business/In	
7	within ene. than "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire					pliments
CA	filed w Hygier Ithar th	Cor	12		busin	ess owne	<del></del>				g mineral
and and	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other than 'natural', or items eumatic avant, The Madical Examinet on	Be	17. Father's Name (First, Middle, Last)  John Van Emburgh					ame (First, Middle  Robinso		ımame)	
<u> </u>	should nd Men marke umatic	7		D	401 11 11	411					
	d 2 sl th and 7 Is r treur		19a. Informant's Name/Relationship (T)			ng Address (Street					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hyglene. Important: If item 27 Is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic avant, the Medical Exeminar must be notified at any injury or other treumatic avant. The Medical Exeminar must be notified at ance.		Donald V. Graf - S  20a. Method of Disposition		20b. Place of Dispo	Rousby sition (Name of		Date		land 20 tion - City or To	
Baltimore,	Pages nent of I ant: If itu ary or o		1 ☐Burial 2 ☐ Cremation 3 ☐F  4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cemetery, crei	matory or other pla	1				
	artme artme ortan injur		21. Signature of Funeral Service Licens	Hener dyr	illcrest	Cemetery 2. Name and Addre		14 2004	Pitmar	New J	ersey
Ba	permit. Departr Importa any inji		BARBARA RAUSCH	-				Rausch :	Funera	al Home	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the	death. Do not ent	05 Broome er the mode of dyi	S IS. R	d. Port ac or respiratory a	Republ	ic MD	20676 Approximate
	Physician		Immediate Cause (Final								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a co	onsequence off:	Recio	(en)				
	Examiner			**							
	n =	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):					1	
	rcuter nd transi	Examiner	Cause (Disease or injury that initiated events	:							
Ö,	icate be executed physician and the burial-transit	Ä	resulting in death) Last	Due to (or as a co	nsequence of):						
8/60,	ate b hysic the b	dlcal		J				······································			
	entific ling p e as	Mec	IF FEMALE:						J	· ·	
Rox	death certific e attending p id for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p	Fetal death 3	Ectopic pregnanc	у		23d	I. Date of delive Month	ny Day Year
oj.	0 0 0	ysic	1 ☐ Yes 2 ≅ No 9 ☐ Unknown	4□Pregnant at time 9□ Unknown	of death 5L	Other (specify) _					July Foul
J.	that the diseased by the	'Ph	Part II. Other significant conditions cor	ntributing to death but no	at resulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use	contribute to th	ne cause of death?
Records,	es be	d by	, and the second	3	<b>3</b>	, <b>g</b> g		1 🗆	,		ably 4 Unknown
Ö	w requir been si should	Completed						04- 146-	10		
Ě	The lav	dm						24a. Was auto	osy ormed?	prior to cor death?	psy findings available npletion of cause of
		ပိ	25. Was case referred to medical					1 ☐ Yes	2.00	1 🗆 Yes	2 <del>5</del> 500
5	Phyaician: this certific ral director,	O B	examiner?	lospital:	2 ER/Outpatier	t 3 DOA		eath <i>(Check only o</i> Home 5 🗆 Resi		Other (Specifi	De sistan
		$\vdash$	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur	y at	28d. Describe			in 7 Feulix
0	ottanding death. ctor: Aft y the fun	atlo	1. ■Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ar) Injury	Wor M 1□	rk? Yes 2 □ No				/ / 1010
DIVISION	or Attanding after death. Diractor: After in by the fune	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str	eet, factory, office		28f. Location (	Street and N	lumber or Rura	Route Number,
2	ital or A rs after el Dirac led in by	Certification:		bonding, etc. (3	p-00///			City or To	m, Sidle)		
	To tha Hospital or Attanwithin 24 hours after deal To tha Funarel Diractor: completely filled in by the	edical (	29a. Certifier Certifying Phys	sician: To the best of m	y knowledge, death	occurred at the tir	me, date and place	ce, and due to the	cause(s) and	d manner as st	ated.
	tha hin 24 tha F	Medi	one) and manner stated.								
	o To Mil	~	29b. Signature and title of certifier	079		29c. Licens				igned (Month, I	Day, Year)
			X1/1								1 4
				Mon			76/0		June	7, 2	004
ı	,		30. Name and address of perso o co			Print)			June	7, 2	004
	6 Sta		30. Name and address of perso o concept of the conc		Frederic	Print)	678		June	7, 2	004

unpend item#23a,27,28a-f,PER ME,G833,7/22/04eg Michael Joe Humple Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-04214 State of Maryland / Department of Health and Mental Hygiene M.E.S 1 - State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** MICHAEL JOE HUMPLE 6 27 2004 3:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 8. Date of Birth (Month, Day, Year) SEPT 14, **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days Hours XXM 2□F Min. 219-08-9416 18 Yrs. 1985 MARYLAND Director Usuel Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla nathrent of Health and Mantal Hygiene. ortant: If itam 27 is marked other than "natural", or Itams 23s or 28e-f show injury or other traumatic event, the Medical Expression and the sofilier an injury or other traumatic event, the Medical Expression and MARYLAND CARROLL 1XXes 2□No Director WESTMINSTER 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 288 EAST MAIN STREET 21157 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status XXNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify: þ Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LABORER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DENNIS WILLIAM BOONE DEBORAH JEAN HUMPLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH J. HUMPLE/MOTHER WESTMINSTER, MD 288 EAST MAIN STREET, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 🛣 emation 3 ☐ Removal from State permit. Page Department o Important: If any injury or CARROLL CREMATION 7/2/2004 HAMPSTEAD, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A. 21. Signature of Funeral Service License Julas 91 WILLIS STREET, WESTMINSTER, MD 23a. Part1. Enter the disease, or complications that cause of the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Oxycodone Intoxication /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or trijury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of) attending physician for use as the buria Box 68760 pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Αq 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \sum No 24a. Was an autopsy performed certificate 1 Yes 2 No Division of Vital To the Hospital or Attanding Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 🗌 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yee 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 3:23 p м 6/26/04 death. 1 ☐ Yes 2X No unknown 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide found in a residence 301 E Main St., Carroll Co., MD within 24 hours a To the Funaral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME June 28, 2004 death (Item 23a) (Type, Print) 111 Penn Street, Baltimore,

State Registrar Date filed (Month, Day, Year)

32. Registrar

Physician

/Medical

**Examiner** 

10a State

12

21. Signatus

IF FEMALE:

examiner

1 Natural

2 Accident

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

**Funeral** 

Director

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Pages nent of 1 permit. Pages Department of Important: If it any injury or o Director

by Funeral

Completed

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

traumatic avant, the Medical Examinar must be notified at

the Maryland

72 hours after death

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month CALVIN GRASON HORNEY 2004 June 6 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death albot The Memoria Pita Easton Hos If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1**▼**M 2□F 218-16-8340 Yrs 80 MAY 8, 1924 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No TALBOT EASTON 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 PARK LANE 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ▼ Married 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INSURANCE SALES INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) RICHARD HORNEY EVELYN HORNEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FLORENCE HORNEY/WIFE 3 PARK LANE, EASTON, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State WOODLAWN MEMORIAL PARK I XBurial 2 ☐ Cremation 3 ☐ Removal from State ^ 4 ☐ Donation 5 ☐ Other (Specify) 06/22/2004 EASTON, MD Fyneral Sewige Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final زرعك Jepsis disease or condition resulting in death) Due to (or as a consequence of): accident Cerebio vasivar Zarel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Onknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death Check on one Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00051132

29d. Date signed (Month, Day, Year)

6-16-04

The law requires that the death certificate be executed as the burial-transi Hospital or Attending Physician: After Director: hours after within 24 hours a To the Funeral L To tha

State Registrar

JORGE ABREGO M.D., 598 CYNWOOD DRIVE, EASTON, MD

31. Date filed (Month, Day, Year) 32. Registra Signature 17 2004

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 18, JUNE 2004 02:35 A M Russell G. Hall /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**個** M 2□ F Director 216-40-0709 60 May 15, 1944 Maryland Usuel Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 1 Yes 2 No Directo 28a-f s Maryland Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 3408A Courtleigh Drive Itams 23a 21244 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes 2 No If Yes, Give Year or Dates:1963-1964 1 ☐ Never Married 2 ☐ Married ŏ 1 ☐ Yes 2 INo þ Specify: Specify: 3 | Widowed 4 | Divorced "natural", white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 machine repairer repair company 27 Is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should ba fill and Mental H Be ဥ Mary Perrie

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Percy Hall . c., Mc.
....mit. Pages t and 2 shc.
Department of Health and M.
Important: If item 27 1any injury or r.\*\* 19a. Informant's Name/Relationship (Type, Print) Shirley Atwell/ sister 11 Taney Avenue Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery June 21, 2004 Annapolis, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARCINOID TUMOR OF LUNG UNKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine law requires that the death cartificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown baan signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC OBSTRUCTIVE LUNG DISEASE 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificata has all director, page 2 autopsy performed? Yes 2 4 No 1 ☐ Yes : After this certifical funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural within 24 hours after ucc...
To the Funeral Director: After 5 Pendina investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or A 24 hours after 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19402 JUNE 18, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

SUKH DEV S. AUJLA, M.D.

JUN 2 1 2004

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

RUSSELL

PHYSICIAN: HALL,

KNOWN TO

NAME

Box 68760,

P.O.

Division of Vital Records,

Baltimore, Maryland 21215-0036

32. Digistrar's Signature

VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 3:38 PM 14 2004 <u>John Christopher Harbold</u> June /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 1109 Primrose Court #204 <u>Annapolis</u> Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**₫** M 2□ F 58 095-36-3526 Yrs. Director 1945 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at 1 Wes 2 □ No Directo Maryland Anne Arundel **Annapolis** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1109 Primrose Court #204 21403 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give 1968-1972
Year or Dates. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 6 No ģ Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is 1 and 2 should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) communications technician state government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Harbold Mae Louise Reynolds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Klipper/ sister 81 Maryland Avenue Freeport, NY 11520 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of H ant: If ite 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or Injury or \* 4 ☐ Donation 5 ☐ Other (Specify) June 19, 2004 Baltimore, MD Baltimore Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last Due to (or as a consequence of) Examine ending physician and use as the burial-transit certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No. the detached 9 Unknown 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 : certificate has autopsy performed 1 Yes 2 No Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only ope) Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 - No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner a eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 1 - Taturai 5 Pendina death. investigation м 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical the 29b. Signature and title of certifier 29c. License number 30. Name and address Aperson who completed cause of death (Item 23a) (Type, Print) ate Ed ste 211 Annapolis mo Curtis Mamis 688 31. Date filed (Month, Day, Year)

JUN 1 8 2004 gistrar's Signature State Registrar

			1 - For State Registrar	State of Maryla		partmen ertificate				Reg. No		21144
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last)  Ber 4. 4. 4. 4. 4. 4. Facility Name (If not institution, give:	ymakor		4b. City,	Town, or Lo	cation of De	2. Date of D Month ath	Da	Year 7 3009 . County of Dea	3. Time of Death  ///// M th
	Funeral Director		Anne Arundel Medi 5. Social Security Number 6. Sep 216-44-9409 Usual Residence of Decedent		s. last birthd	ay) If Under Months		Under 24 H lours Mi		irth Day, Year)	ne Arur	ndel thplace (State or Foreign ountry) Virginia
	he Maryland 28a-f show	Director	10a. State 10b. County  Maryland Anne Aru		City, Town or	ĽS	0.1			40-0		10d. Inside City Limits 1 ☐ Yes 2 ♣ lo
036	De lied within 72 hours atter death with the Maryland klat Hygiene. Ald chief than "natural", or items 23a or 28a-f show event, the Medical Evanifier must be notified at	by Funeral	10e. Street and Number  6 Willow Street  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 1	3. Was Deced	.401 lent of Hispa ify Cuban, M	nic Origin? Mexican, Pue pecify:	(Specify Yes or Nerto Rican, etc.)	Unit	ted Stat  14. Race - Ame Black, White  Specify: Wh	CES enican Indian, te, etc.
d 2121	e tiled within Il Hygiene other than " ent, the Me	Be Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 3  17. Father's Name (First, Middle, Last)	cation e <i>completed)</i> College (1-4or 5+)	(G life	cedent's Usua ive kind of wor e. DO NDT us inen su	k done durir se retired) sp <b>ervi</b> :	ng most of w	orking ame (First, Middl	nav	ral hosp	
Marylar	of 2 should lith and Mer 27 is marke r traumatic	ToB	Jinks Davis  19a. Informant's Name/Relationship (Ty. Bonnie Davis/ niec				(Street and	Number or I	Taylor Rural Route Number			Zip Code)
altimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tri once.		20a. Method of Disposition  1  Burial 2  Cremation 3  R  1  Onation 5  Other (Specify)  21. Signature of Funeral Service License	C			metery		Date  1e 21, 20  John M. 5	104 S		
P	R 스 트 등 등 등 가능하는 기계 기계 기계 기계 기계 기계 기계 기계 기계 기계 기계 기계 기계		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consi	ath. Do not sequence of):	147 Duk	e of (	Glouce	ster St.	. Ann		Approximate Interval Between Onset and Death
١.		ledicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consi	equence of):	A						DAYS
P.O. BOX 58	ine law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death	3 □Ectopic pre 5 □ Other (spe					23d. Date of del Month	ivery Day Year
Oras, r	w requires that been signed b should be deta	by	Part II. Other significant conditions con	atributing to death but not re	-	e underlying ca	ause given in	Part I.				the cause of death?
tai Hec		e Completed	25. Was case referred to medical				26	Place of D	24a. Waa auto perf 1 □ Yes	ormed?	24b. Were au prior to death?	topsy findings available completion of cause of
Division of vital Records,	d is	ertification; To B	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: Inpatient 2  28a. Date of Injury (Month, Day Yeer)	ER/Outpat 28b. Time Injur	of 28	A Other: 2 Bc. Injury at Work?		Home 5 Res	idence (		cify)
DIVIS	in the second	O	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injury - At building, etc. (Special):	oify) 			lata and -!	City or To	wn, State	)	ral Route Number,
1	within 24 hours a To the Funeral C completely filled	Medical	(Check only one)  2 Madicel Examir  29b. Signature and title of certifier	ner: On the basis of examinand manner stated.	nation and/or	investigation,	in my opinio	n, death occ	curred at the time	, date and	and manner as place, and due e signed (Mont/	to the cause(s)
•	- ≤ ⊢ ŏ		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Tvo	O Drint			7		06/17/2	2004
	Sta Registr		STC EOWO DAN  31. Date filed (Month, Day, Year)  JUN 18	2004 32. Reputrar's Sign	nature	AAM .	c A	HUNA	POLIS	MI	214	0/

			1 _ State		artment of Health and Martificate of Death	Mental Hygie		0111
			Registrar  1. Decedent's Name (First, Middle, Last)		Timeate of Death	2, Date of Death	NS () ()	3. Time of Death
	Physici /Medic		DONALD WARREN HUMBLE,	SR.		June 1	Day Year	00:20 AM
	Examin	er	4a. Facility Name (If not institution, give street and num WASHINGTON COUNTY HOSPIT		4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASH	HINGTON
	Funeral Director		5. Social Security Number 6. Sex 1. 1 X M 2 □ F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye FEB. 20,	9. Birth 1943 PENN	nplace (State or Foreign untry) ISYLVANIA
	yland now		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	the Mar 28a-f sl	ector	MARYLAND WASHINGTON  10e. Street and Number		BOONSBORO	100	Civina at 1911 at C	1 ☐ Yes 2X No
	h with	al Di	20832 NATIONAL PIKE		21713	Tog.	Citizen of What Co	•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel; or Items 23e or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decender Armed For 1 Wes Pare of Davis 1 Wes Pare of Davis 1 Never Nev	2 No. 25, 00	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Brican, etc.)	14. Race - Amer Black, White Specify:	
Maryland 21215-0036	72 hou	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of work	king 16b	. Kind of Business/I	
121	I within iene.	Completed	Elementary/Secondary (0-12) College (1-	life.	DO NOT use retired)  Truck Driver		rucking (	'omnany
nd	al Hyg d other	Be C	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid		omparry
ryla	hould to d Ment marked matic e	2	DONALD WARREN HUMBLE	106 44-10	EDNA WA			
Ma	alth and 2 si		19a. Informant's Name/Relationship (Type, Print)  DONALD W. HUMBLE, JR.		ng Address <i>(Street and Number or Rui</i> CKELDIN DRIVE, BO			21713
Baltimore,	ges 1 a t of Hea If item or othe		20a. Method of Disposition 1	late	natory or other place)		. Location - City or 1	
Ħ E	artmenl ortant: injury		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fay and Servic License	BOONSBOR	O CEMETERY 6/24,	/2004 BO	ONSBORO,	MARYLAND
Ba	Depa Impo any it		1 Textex		BAST FUNERAL HOME		O, MARYLA	
	Physician		23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition	used the death. Do not ent ch line.	t .	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner			or as a consequence of):	Infarction	\		
	sit s	iner	causa. Enter Underrying	or as a consequence of):	Melitus			
oʻ	rate be executed hysicien and the burial-transit	Examiner	that initiated events c.	or as a consequence of):	Tare II ( w)	<del></del>		
8760,	physici the bu	dical	d					
P.O. Box 6	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physiclan/Med	in the past 12 months?	nt at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delive	rery Day Year
	uires that the signed by Id be detac	by	Part II. Other significant conditions contributing to de-	ith but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to t	the cause of death?
ecor	e law requir has been s ge 2 should	Completed				24a. Was an autopsy	24b. Were auto	opsy findings available
Vital Records,	The ate h page					performed	death?	ompletion of cause of
	ysicier s certil directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 In	patient 2 - ER/Outpatien	Other	h Check onlone me 5□ Residence	6 □Other (Speci	6/1
Division of	Attending Physicien: r death. ector: After this certifice by the funeral director, i		27. Manner of Death  1 ☑Natural 5 ☐ Pending (Month)  2 ☐ Accident investigation			28d. Describe how in		.,,,
Divis	2 # # c	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of	of Injury - At home, farm, stre g, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta		al Route Number,
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)  1 Cartifying Physician: To the base and manner and mann	sis of examination and/or inv	occurred at the time, date and place, restigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as s and place, and due t	stated. o the cause(s)
	To the within To the compl	5	29b. Signature and title of certifier		29c. License number	29d. [	Date signed (Month,	Day, Year)
)	0.X\		Jany mind		D0060396		06/19/0	4
	54		30. Name and address of person who completed cause FARID MULSH	of death (Item 23a) (Type,	Opal Court Ha	gerstown	Marylo	and
	Sta Registr	te ar	30. Name and address of person who completed cause FARID MJL SH  31. Date filed (Month, JUN 2 2 2004 32. R	Sistrar's Signature	berke			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death S. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22°, **Physician** JUNE 2004 BESSIE ANNA HUMBLE 0015 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 20832 NATIONAL PIKE **BOONSBORO** WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. AUG . 7, 193 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Birthplace (State or Foreign Country) 1 □ M 2 XF Yrs. 577-46-7742 68 Director MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event. The Modical Examiner must he action once. 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 1 ☐ Yes 2 X No Directo MARYLAND WASHINGTON **BOONSBORO** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20832 NATIONAL PIKE 21713 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANAGER RETAIL SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HERBERT C. DICKEY GERTRUDE ANNE CARR ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONALD W. HUMBLE, JR. 12 MCKELDIN DRIVE, BOONSBORO, MARYLAND 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BOONSBORO CEMETERY i6/24/2004 BOONSBORO, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) uneral vivice Licenses 22. Name and Address of Facility 7606 OLD NATIONAL PIKE BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Dheochronocytona disease or condition resulting in death) years /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? ector, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2€ No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ŧ 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To 3□ DOA this After this funeral of 27. Manner of Death 1 Natural Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation s after dea. al Director: Aftr 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sathleen 032073 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North are Brunswick NS 610 Kathleen W. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 2 2004 Registrar

			1	State of Man		indelible ink epartment of h		•	•	
		•	For State Registrar		-	ertificate of			g. No 2 1 1 1	01117
			1. Decedent's Name (First, Middle, L	ast)				2. Date of Death Month	Day Year	2. Time of Death
	Physicia /Medic			June 1	F. Hi	L1		June 29,	2004	10:20 A M
	Examin		4a. Facility Name (If not institution, g	ive street and number)			or Location of Death		4c. County of Death	1
			Union Hospital  5. Social Security Number 6.	Sex 7. Age (	In yrs. last birtho	Elkton		8. Date of Birth (Month, Day,	Cecil 9. Birth	nplace (State or Foreign
	Funeral Director		181-10-1975	1□M 2\ F 8	_	Months Davs	Hours Min.	(Month, Day, 'May 12,		nplace (State or Foreign untry) Osylvania
	ס		Usual Residence of Decedent		0c. City, Town o	a La castia a				10d. Inside City Limits
	shov	5	10a. State 10b. County Maryland Cecil	"		ng Sun				1 ☐ Yes 2X No
	the N 28a-f	rect	10e. Street and Number		TOTAL	10f. Zip Code		10	g. Citizen of What Co	untry?
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evantinar must be notified at	Completed by Funeral Director	1881 Telegraph H	Road			21911	τ	Jnited Stat	tes
	deatl	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of H	Hispanic Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	s after or It	Z.	1 Never Married 2 Married	1 □ Yes 2 🕅 No If Yes, Give		1 ☐ Yes 2X No			Specify: Wh	
Maryland 21215-0036	hour tural	ed b	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:	16a, D	ecedent's Usual Occur	pation	10	6b. Kind of Business/I	
215	nn 72	plet	(Specify only highest of Elementary/Secondary (0-12)	rade completed)  College (1-4or 5+)	1	live kind of work done fe. DO NOT use retire	nd)	ng	Confection	
21	ad with	E O	12		C	andy Maker	1		Manufactu	ring
pu	be file d oth	Be	17. Father's Name (First, Middle, Lat				18. Mother's Name		aiden Surname)	
ryla	should nd Men marke	ဥ	Claude B. S		19h N	lailing Address /Street	Ella M.		City or Town, State, Z	in Code)
Ma	nd 2 slitth an 127 lar		Linda A. Hull/I						Maryland	
ē,	permit. Pages 1 an Department of Heal Important; If itam 2 any injury or other once.		20a. Method of Disposition			isposition (Name of crematory or other pla			0c. Location - City or 1	
E	Page nent o int; If		1∑ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Special)	THEMOVALITOM State		zwald Cemet		, 2004	Jacksonwal	đ, PA
Baltimore,	permit. Departminitude Imports any inju		21. Signal re of Funeral Service Lic	ensee		22. Name and Addre Hicks Home	ess of Facility For Fune	cals, P.	Α.	
	20599		Donned.	S. Huko	<b>)</b>	103 W. Stc	ckton St.	Elkton	MD 2192	
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each line.		3-			St,	Approximate Interval Between Onset and Death
8	Pnysician /Medical	ů	disease or condition resulting in death)	a. Toute	155	Watery	Tailu	re		2 24 hours
	Examiner		THE DESIGNATION OF STREET	. Advit (	consequence	ory distr	ess Symo	laws-		14 low,
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence of		-			2
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760,	e be exec fed rsician and e burial-transit	a E	Toodking in dodkiny Educ	Due to (or as a c	consequence or,	,	/	/		·
687	leath certificate I attending physi			d						
Box (	death certificate e attending phys d for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		3□Ectopic pregnanc			23d. Date of deli	very
œ.	0 0 2	sicia	in the past 12 months? 1 🗆 Yes 2 🗷 No	4☐Pregnant at tin		5 Other (specify)	·y		Month	Day Year
P.O.	that the de ed by the detached	P.	9 Unknown				is Book!	22a Did taba	acco use contribute to	the equal of death?
	law requires that the as been signed by th 2 should be detache	ρ	Part II. Dther significant conditions	_	TJE41C	ne underlying cause gr	ven in Part i.	239. Did (008		bably 4 Unknown
Sor	v requ been should	Completed	1. 10 16 16		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			24a. Was an	Time	topsy findings available
Re	0 5 0	ш	14000000	menia				autopsy perform	ed?/ prior to c	ompletion of cause of
of Vital Records,	ifcian: Th certificate rector, pag	O	25. Was case referred to medical	- 2			26. Place of Death			2   NO
<u>&gt;</u>	S S	To B	examiner?	Hospital:	2 ER/Outp	atient 3 DOA Ot	her: 4 🗌 Nursing Hor	ne 5 🗆 Residen	nce 6 Other (Spec	ify)
	ing Pl	on:	27. Manner of Jeath 1 ZNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Tin	iry Wo	ork?	28d. Describe hov	v injury occurred	
Division	Attending it death. ector; Alter by the fune	Icat	2 Accident investigat 3 ☐ Suicide 6 ☐ Could not	be One Blace of Injury	- At home, farm	M 1 [	]Yes 2□No	28f. Location (Stre	eet and Number or Ru	ral Route Number.
Div	of or Attency after death Director; d in by the	Certification:	4 ☐ Homicide determine	building, etc.	(Specify)	, otroot, radiary, ombo		City or Town,		,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral			Physician: To the best of aminer: On the basis of e						
	To tha He within 24 To the Fe complete	ledical	one)	and manner state			se number			
	To Tool	Σ	29b. Signature and title of certifier						d. Date signed (Month	• • • • • • • • • • • • • • • • • • • •
•	d	8	30. Name and Indress of person wh	on completed cause of dea	th (Itam 23a) /T	(De Print)	, 3 3 7 7 6		Nuc ort	, 2001
	'		Alfred A Pinn	MD, Union	HUSpi	tal 106	Bow ST	reet,	Ture 29, CIKton	MD
	Sta		31. Date filed (Month, Day, Year)	32. Registrar						
	Regist	rar	JUL 07	2004 Bens	va /	y soon	Cof :			

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

		partment of Health and I ertificate of Death	Reg. No 2 () ()	4 21148
Physiciar	1. Decedent's Name (First, Middle, Last)  Jean Gerlaugh HILL		- 00 000	3. Time of Death  4 12:08 a.m.
/Medica Examine	As Facility Name (if not institution give street and number)	4b. City, Town, or L		
Examine	19513 Foxcroft Drive	Hagersto		
Funeral Director	5. Social Security Number 6. Sex 1 □ M 2 □ F 7. Age (In yrs. last birthde 85 Yrs.	Months Davs Hours Min.	8. Date of Birth (Month, Day, Year) August 7,1918	). Birthplace (State or Foreign Country) Ohio
and	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
Mary 1 sh	Maryland Washington Hagers	town		1 ☐ Yes 21 □ No
or 28	10e. Street and Number	10f. Zip Code	10g. Citizen of Wh	
e 23e	19513 Foxcroft Drive 11. Marital Status 12. Was Decedent Ever in U.S. 1	21742  3. Was Decedent of Hispanic Origin? (Si		S.A. American Indian,
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Modical Examinar must be notified at once.	11. Marital Status  Armed Forces?  1 □ Never Married 2⊠ Married  1 □ Ves 2 □ Never Married  3 □ Widowed 4 □ Divorced	Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerform 1 ☐ Yes 2 ☒ No Specify:	Black, Specify:	White, etc. white
21215-0020 bd within 72 hours af gione. than 'natural', or than 'natural', or the Modical Exam	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of wor g. DO NOT use retired)	16b. Kind of Busin	ness/Industry
within within the Men	3 Widowed 4 Divorced Pyes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 0-12 4  16a. De (G) (G) (G) (G) (G) (G) (G) (G) (G) (G)	homemaker	her ow	n home
ind 2 be filed tal Hygid d other event, is			ne (First, Middle, Maiden Sumame)	
aryland 212: should be filed within and Mental Hygiene. in marked other than umatic event, the M	Ernest Harry Mills		Bertha Gerlau	0
Maryland of 2 should be file the and Mental Hy the and Mental Hy tre is marked other treumetic event	19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address <i>(Street and Number or Ru</i> 29 Smithsburg Pike		
re, N 1 and 1 Health tam 27 other tr	200 Method of Disposition 20b Place of Di	sposition (Name of crematory or other place)	Date 20c. Location - Ci	
Pages Pages nant of Internet into or o	11 Buriol 2 NC comption 3 I Pomoval from State	O	June 21, 2004 Hagersto	own, Maryland
Baltimore, permit. Pages 1 ar Department of Hea Important: if flam; any injury or othe	21. Signature of Funeral Service Licensee	22. Name and Address of Facility 415 East Wilson Blu	Minnich Funera d., Hagerstown,	
\ Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
/Medical	Immediate Cause (Final disease or condition e. DNewMA			orlan
	Due to (or as a con	sequence of): Through()		nlinum
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68760, ficata be axecuted physician and s the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c.			
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Box 6 auth cartifi attanding for use as				
death death na atta	d	e underlying cause given in Part I.	23b. Did tobacco use contr	ribute to the cause of death?
P.O.			1 ☐ Yes 2 ☐ No 3	3 ☐ Probably 4 dunknow
Cord			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
I Rec			1 Tyus 2 No	1 ☐ Yes 2 ☐ No
Vital	25. Was case referred to medical		th (Check only one)	
on of Vital Rec ing Physician: The law h. After this certificate has funaral director, page 2	1 ☐ Yes 24 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa		lome 5 Residence 6 Other 28d. Describe how injury occurred	
- D 0 0	1 Natural 5 Pending (Month, Day Year) fnju		250. 2500.120 1.01,2.,	
Division  or Attending I after death. Director: After d in by the funa.	27. Menner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Dete of Injury (Month, Day Year) 28b. Imm (Month, Day Year) 28b. Imm figure 28b. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street and Number City or Town, State)	r or Rural Route Number,
	29a. Certifier (Check only one)  1 Certifying Physicfan: To the best of my knowledge, dependence on the basis of examination and/or and manner stated.	eath occurred at the time, date and place ir investigation, in my opinion, death occu	, and due to the cause(s) and mani rred at the time, date and place, ar	ner as stated.  nd due to the cause(s)
To the comp	29b. Signature and title of certifier	29c. License number		(Month, Dey, Year)
34-3	30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print) educal Cungus Re	3 June 2	1, 2004
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Stat Registra	. III N C 1 (1) 14 1 15 2 2 2 2	Speciel		

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar# 23A, Per Physician, 6/18/04, Certificate of Death WCHD, C.H. Reg. No. 10 11 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 06 00:06 Phillip Hill04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO EGION M PONINSULA Edilas SAVISBUIL If Under 1 Year | If Under 24 Mrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 ☐ F Director 84 January 8, 1920 Maryland 213-14-1449 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Itams 23a or 28e-f sh irer must be notified 1XYes 2 □ No Directo Maryland Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 213-14-144 Completed by Funeral 1210 Market Street, Apt. A-7 21851 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No Army If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. other traumatic event, the Medical Examiner illed within 72 hours after 1X Never Married 2 ☐ Married ō 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Military US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H Hill Clara Ellen Fisher ٩ William Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 Ellen Wilson (niece) 380 Sunset Road, Mountain Top, Pennsylvania 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ŏ Importent: If it any injury or c 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) June 16, 2004 Salisbury Crematory Salisbury, Maryland 21. Signature of Funeral Service Licensee Holloway Melson Funeral Home P. A. 103 Linden Avenue, Pocomoke City, Maryland 21851 can 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Kena I wee K disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** COPD Sequentially list conditions, Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physiclan/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a detached f P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, p Be Completed 1XXYes 2□No 3□Probably 4□Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death Check onl o examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA te of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To tha Funaral Diractor: A 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D418/3 6-15-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Mine 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State JUN 1 8 2004 Registrar

Physici	an	1. Decedent's Name (First, Middle		11 00			2. Date of Dea		3. Time of De
/Medic		Margaret	Elizabeth	Huffer			March	29, 2004	
Examir	ner	4a. Facility Name (If not institution Frederick Met	n, give street and number) Morial Hospit	tal	4b. City, Town, or l Frederic			Frederi	
Funeral Director		5. Social Security Number 215-34-3796  Usual Residence of Decedent	104 205	e (In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day May 20	y, Year) 0, 1915	Birthplace (State or F Country) MD
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3a or 3	Dir	10e. Street and Number 321 S. Jeffe	erson St.		10f. Zip Code 21	769		10g. Citizen of What	Country? USA
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Department Important: I any injury o		21. Signature of Funeral Sprice	Lie Insee	Í	22. Name and Address Oonald B.	of Facility Thomps	on Fur	neral Ho	me
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend Items 21,27 per Me, FH, G832 Medic of Department of Health and Mental Hygiene

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 2004 Kuchard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brown Rd.

7. Age (In yrs. last birthday) How ard Owen If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 10M 2□F Days Yrs. 219-56-650 Usual Residence of Decedent Director OCTO120/25, 1948 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28e-f show The Modical Examinat must be notified at 1 Yes 2 No thoused MD Columbia Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. A 21045 23a 9824 monore fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 22 No If Yes, Give Year or Dates: Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Pages 1 and 2 should be filed within 72 hours aftinent of Health and Mental Hygiene.
int: If item 27 is marked other then "neturel", or it 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) None Workshop Employee 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dorothy Guy William thud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13003 Creagestown Kol Thurmont MD 21788 William F. Harper, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 remation 3 Removal from State 0 permit. Page Department of Important: If any injury or once. Smithsburg Cermatory May 8,2004 \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee We Son Funeral Homos, PA Main St. Thurment, MD Robert E. DaileyIII per DVR MD 21788 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Months Physician Hematoma Subdural /Medical Due to (or as a consequence of): **Examiner** ON APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No be detached for Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Discore 1 Yes 2 No 3 Probably 4 Unknown emor's 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5, Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of After 5 Pending investigation atural Accident s after death. 1:001 December 1,2003 1 ☐ Yes 2 ☑ No rall the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office, building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Columbia 4 Homicide City or Town, State) within 24 hours a
To the Funerel C
completely filled To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 516 ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who compl

Registrar

State

rew

31. Date filed (Month, Day, Year)

JUN 2 4 2004

32. Registrar's Signature

West

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Elwood Milton Hoffman June 3:10p 26 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20861 Old York Road Parkton Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 216-24-8044 76 **Director** February 14,1928 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov the Medical Examiner must be notified at 1 Yes 27 No MD Baltimore Parkton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 20861 Old York Road 21120 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: If Yes, Giro Year or Dates: Specify: 3 Widowed 4 Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 6 Truck Driver Transportation other 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be item 27 is marked of Charles Milton Hoffman Geneva Hare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen R. Hoffman/Wife 20861 Old York Road Parkton, MD 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of F Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Wiseburg Cemetery June 30,2004 White Hall, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. Second St. New Freedom, PA 17349 Dans no 23a. Part1 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. | 1 ☐ Yes → No 9 ☐ Unknown the ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Completed 1 Yes 2 🗆 No 3 Probably 4 Unknown Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe (es page this certificate 1 Tyes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 TYes Other: 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home esidence 6 Other (Specify) 27. Manner of Death 28d. escribe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No I Director: d in by the the 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined hours after within 24 hours a To the Funerel I Hospital critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the 29b. Signature 29c. License number 29d. Date signed (Month, Dey, Year) nth (Item 23a) (Type, Print) ポラハ 30. Name 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Flossie Johnson 2004 8:15 13. June /Medical 4b. City, Town, or Location of Death Solomons 4c. County of Death
Calvert 4a. Facility Name (If not institution, give street and number) Examiner Solomons Nursing Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | A u g . 28, 1910 9. Birthplace (State or Foreign Country)
1 and 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🂢 F 216-10-1606 93 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23s or 28s-f show ury or other treumatic event, it a Medical Exeminar must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Lusby Director Calvert Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20657 USA 621 Lisa Lane Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🗓 No Specify: Black If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Someone Else's Elementary/Secondary (0-12) College (1-4or 5+) Home Domestic 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be John Bishop Matilda ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lusby, MD 20657 Warren Beverly/son 12510 H.G. Trueman Rd. 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a Method of Disposition 1 ABurial 2 Cremation 3 Removal from State St. John UMC Cem. 6/19/04 Lusby, MD permit. Pag Department Important: I any injury o 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Fred., MD20678 21. Signature of Funeral Service Licenses Gladip 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 minutes Pnysician Cardiac Arrhy thinga /Medical Due to (or as a consequence of): more than **Examiner** Cordio voscular disease therosciesonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physiclan/Medical Examiner the Hospitel or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 1 No detached 9□ Unknown 9 Unknown been signed t should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☑ Onknown Vascular 1 Tyes 2 No. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Ulcer 24a. Was an autopsy performed? Heart tuppesten sive 1 Yes 2 No Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No ို 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification; 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier sunana. 50653 6-15-2004 1400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYAN . C - SURDAN I Road. Deale m.D. 5851 -Dealechwichton 31. Date filed (Month, Day, Year) 32. Registras Signature State Registrar

			1 _ State	State of	Marylan				l Mental Hygi	iene	
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	Physic				kisch				Month	Day Year	C. 45 AM
	/Medi Examir		4a. Fecility Name (If not institut	on, give street and num	ber)		4b. City, Town, o	r Location of De		6, 2004 4c. County of Deatl	2:45 A <sup>™</sup>
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			1 - For State Registrar	State of Mary	land / Dep	artment of F	lealth and		giene Rog. No 2 1	14. 21155
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Maryiand 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Important: if item 27 is marked other then "netural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Dece (Giv. life.	edent's Usual Occup e kind of work done DO NOT use retire	during most of w d)	vorking		ile Industry
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Baltimore,	permit. P Departme Importani any injury once.		21. Signature of Funeral Service License		1.3		ess of Facility I	ee Funer	al Home (	Calvert, PA gs, MD 20736
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0	d is	2	1 No Pes 2 No Peath	lospital: 1 Inpatient	2 ER/Outpati	ent 3 DOA		g Home 5 Mesi	dence 6 Othe	
on	fter	tion	1 atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ear) Injury	Wo	ork? ]Yes 2 □No			
Division	of or Attending after death.  Director: After din by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	· At home, farm, s Specify)	street, factory, office			Street and Numbe wn, State)	er or Rural Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical C	29a Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of ner: On the basis of ex	amination and/or	ath occurred at the tinvestigation, in my	ime, date and pla opinion, death of	ace, and due to the courred at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
	To th withir To th comp	Me	296: Signature and title of certifier	11 0/_		29c. Licen	se number		29d. Date signed	(Month, Day, Year)
•			tayle		<i>*</i>	101	1)32	4	Gal/	
	12		30. Name and address of person who co	ple ed cause of eat 32 Cox Ros			<b>I</b> D			
		ate	31. Date filed (Month, Day, Year)	32. Registras						
	Regist		JUN 2 1	7004	Aug H.	marke	•			

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	ı Memai my	Reg. No 2 1 1 1	21156
	-0		1. Decedent's Name (First, Middle, Last)	2. Date of Do	eath	3. Tirne of Death
1	Physici /Medi		Lorraine Elizabeth JACKSON	June	Day Year 17 2004	
	Examir			or Location of Deat		
1			Julia Manor Nursing Home Hager	stown	Washir	ngton
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H			inthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	July 1		aryland
	ylend		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	ath with the Maryler 23s or 28s-f show	Director	Maryland Washington Hagerstown			X□ Yes 2 □ No
	₹ 2 ×	Dire	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	country?
	ath w		617 Adams Avenue 21740		U.S.A.	
	items items	Funeral	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. Race - Am Black, Wh	
21215-0020	\$ 5 E		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Year or Dates:	,	Specify:	Black
5-0	72 hours natural,	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of w	working	16b. Kind of Busines	s/Industry
7	S	함	(Specify only highest grade completed)  (Give kind of work done during most of wild be life. DO NOT use retired)  (Give kind of work done during most of wild be life. DO NOT use retired)	voiking		
	filad withi Hygiene. rther than	S	12 0 Homemaker		Her own	home
Pu	d oth	Be			, Maiden Surname)	
Maryland	ould be Mental Marked o	٥		r May Bu		
Nai	12 sh h end is rr		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or			
	1 end Heelth	- N	Linda Smith - Daughter 309 S. Mulberry Stre	et Hage		
Baltimore,	Pages nant of h int: if ite iry or of		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place)		20c. Location - City o	
뜶	rtmar rtant		4 □ Donation 5 □ Other (Specify) Hagerstown Crematory	6/17/04		n, Maryland
Ba	Dependent of the police of the		21. Six alternal Funeral Service Licensee 22 Name and Address of Facility		Funeral Ho	
			(15 E. Wilson Blv			21/40
1			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	iac or respiratory a	rrest,	Approximate Interval Between Onset and Death
7	Physician /Medical		Immediate Cause (Final			Onset and Death
	Examiner		disease or condition T(asp) (alory Criss)	/		y day
		ē	Due j/o (or as a consequence of):	in	rforales c	
	cate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions,  Due to (or as a consequence of):	al pe	yoraces c	olen
ດົ	execting and an analytic	Exa	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):	/		[ [
68760,	ysicia ysicia	edical	Cause (Disease or injury that initiated events  Due to (or as a consequence of):			
	<b>≘</b> ⊘ 66	940	resulting in death) Last			! 
Вох	th cer endir r usa	Z	d			1
	daal	Sicl	Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.	23b. Did	tobacco use contribut	e to the cause of death?
P. 0.	The law requires that the death cer ate hes been signed by the attendir page 2 should be detached for usa	Physiclan/N	Mara Resit	1 🗆	Yea 2□No 3□F	robably 4 Unknown
	igner bed	2	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1			
Records,	requi	Completed	Hyperten Sign	24a. Was perfo	an autopsy 24b. med?	Were autopsy findings available prior to
ည္ဆ	law 1es b 6 2 si	햩		•		completion of cause of death?
	The cate to peg.		CORD	10	Yes 2 No	1 ☐ Yes 2 ☐ No
<u> </u>	Physician: this certific ral director,	Be	examiner?	eath (Check only o	nne)	
ō	Physical disconnections of the control of the contr	<u>1</u>	1 Inpatient 2 EH/Outpatient 3 DOA 4 Drursing		dence 6 Other (Spe	ocity)
<b>L</b> 0	ding h. After fune	ig	1 DNatural 5 ☐ Pending (Month, Day Year) Injury Work?	200. Describe i	now injury occurred	
S	Attending tr death.  ector: After by the fune	fica	3 Suicide 6 Could not be	28f. Location (S	Street and Number or R	ural Route Number
Division of Vital	or I or I	Certification:	4 Homicide determined building, etc. (Specify)	City or Tov		
	To the Hospital or Attending Physician: The law within 24 bours eftar death, within 24 bours eftar death, To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2.	Saic	29a. Certifier  11 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place.	ce, and due to the	cause(s) and manner a	s stated.
	he H( in 24 he Fu pletel	edicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	curred at the time,	date and place, and du	e to the cause(s)
	To the feet	Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mon	
	A		Ausffrdicke D27898		6/17/04	4
	ph-2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLANCISCO L, ANDRADE 350 MILL ST, HA	GED STON	ex lin	21741
C	W'			JUN JUN	MU	21170
	Stat		31. Date filed (Month, Day, Year)  32. Registrar's Signature			

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 8 37 AM **Physician WILLIAM** JUNE L. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Princess H
If Under 1 Year | If Under 24 Hrs. ANNE Somerset QNOKIN Manor 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours **№** M 2□ F Months 219-56-7833 82 Yrs. Director 6/22/1921 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits rai', or items 23a or 28e-f show Examiner must be notified at 1≹Yes 2 No Director Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a any jnjury or other treumatic event, the Medical Expressions. USA 11974 Edgehill Terrace 21853 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ፩ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disables 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Traynie Outten Fletcher Justice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George F. Tilghman (nephew) 4447 Little Mill Road, Stockton, MD 21864 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 6/22/2004 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salem United Methodist Cemetery Pocomoke City, MD 21. Signature of Funeral Service Licensee HOITOWAY MEISON' Funeral Home, P.A. Ran 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASWA Syums /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed 1 Yes 2 No Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ပ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel within 24 hours a To the Funeral L

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Junky

31. Date filed (Month, Day, Year)

Medical

State

Registrar

SAUSBURY

reale

USHA NATISAN

DIVISION,

32. Refistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1415

JUN 2 2 2004

1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0057359

MD21804

29d. Date signed (Month, Day, Year)

6/21/04

		_	1 - For Stata Registrar	State of	Maryland		artment tificate			and M		Reg. No 2	04	21158
	Dhysisi		1. Decedent's Name (First, Middle	le, Last)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic	al	William	Eugene		Ke					June	16	2004	5:50 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution	n, give street and num	ber)		4b. City, T			of Death			ty of Death	
			803 View St.					erst		04 U			hingto	
	Funeral Director		5. Social Security Number 217–12–2980	6. Sex 1 <b>X</b> M 2□ F	7. Age (In yrs. I	ast birthday) Yrs.	If Under	Days	If Under Hours	Min.	8. Date of Birt (Month, Day June 2	, Year) 9, 1926	9. Birthpla Count Mary	ace (State or Foreign ry) Land
	p ,		Usual Residence of Decedent  10a. State 10b. County	,	10c Cib	r, Town or Lo	cation						10	d. Inside City Limits
	aryla shov	٦												1∑Yes 2 No
	8a-f	Director		ington		Hagers	10f. Zip	0-4-				10g. Citizen o	4 Milhet Count	
	with ti	ă	10e. Street and Number									-	S.A.	
	s 234	eral	803 View St.	12 Was Dece	dent Ever in II	S 13 V	217		spanic Ori	ain? (Sne	acify Yes or No		ace - America	n Indian.
96	be filed within 72 hours after death with the Maryland stal Hygiene. ed other than "naturel", or Hems 23a or 28a-f show event. It e Madical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 🕅 Mar  3 □ Widowed 4 □ Divorced	ried 1 📉 Yes	dent Ever in U. rces? 2 ⊡ No 194 e ites:	6	f Yes, speci		Specify:	n, Puerto	ecify Yes or No- Rican, etc.)	Spec	ack, White, e	tc.
21215-0036	ture sture	Completed by	15. Deceder	nt's Education		16a. Deced	dent's Usual	Occupa	ition			16b. Kind of	Business/Ind	
15	n "ne	piet	(Specify only highe	est grade completed)  College (1-	405 54\	(Give life. l	kind of work DO NOT use	k done d e retired,	luring mos )	t of worki	ing			
212	filed within Hygiene. other than "	E	Elementary/Secondary (0-12)	College (1	401 5+)	Fore	nan					Door Ma	nufact	turing Co.
D	illed Hygi other	a	17. Father's Name (First, Middle,	(Last)					18. Mothe	er's Name	(First, Middle,	Maiden Suma	ame)	
lan	lid be fenta rked ric ev	To B	Freeman Keihl						Mar	у Е				
Maryland	s 1 and 2 should be f Health and Mental B Item 27 Is marked of other treumatic eve		19a. Informant's Name/Relations Catherine A. Ke				ig Address				n, MD	r, City or Tow 21740	n, State, Zip (	Code)
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If item 27 any injury or other tr		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation		State	lace of Dispo	natory or ot	her place			Date		City or Tov	
ţ	rt. Pz rtmer rtent njury		' 4 □ Donation 5 □ Other (S		21117	thsbur					st Have	Smiths		
Ba	Depar Important in any ir	/ 1	> 5. Mark Su	7		16	01 Pe	nnsy	ylvan	ia A	ve. Hag	erstow	n, MD	21742 Approximate
8760,	bath certificate be executed attending physician and attending physician and the private at the burial-transit	ical Examiner	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Up	a	ach line.	uence of):	4		àn cc					Interval Between Onset and Death
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Fetal ant at time of d	Ideath 3□	Ectopic pre						ate of deliver	y Day Year
	uires that l signed by d be deta	by	Part II. Other significant condit	ions contributing to de	ath but not res	ulting in the u	nderlying ca	ause give	en in Part I		23e. Did to			e cause of death?
Records,	The law requir ate has been si page 2 should	Completed						<del>-</del>			24a. Was autop perfor 1 Yes	an 24b sy med? 2 No	were autop prior to com death? 1 \(\sum \text{Yes}\)	sy findings available pletion of cause of
Vital		a l	25. Was case referred to medica	al					26. Place	of Death	(Check only o			
>	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗆 li	npatient 2	ER/Outpatier	nt 3 DO	A Othe	er: 4 □ Nu	irsing Ho	me 5 Resid	lence 6 🗆 O	ther (Specify)	
υot			27. Manner of Death 1 ☑Natural 5 ☐ Pendi	28a. Date of	of Injury h, Day Year)	28b. Time of Injury	28	Bc. Injury Work	at		28d. Describe h	ow injury occi	urred	
<u>ö</u>	Attending r death. ector: After by the fune	atic	2 Accident invest	tigation			М	101	Yes 2□	No				
Division	after de Directo	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	minod 286, Place	of Injury · At hong, etc. (Specify	ome, farm, str y)	eet, factory,	, office			28f. Location (S City or Tox		nber or Rural	Route Number,
_	To the Hospitel or Attenct within 24 hours after death To the Funerel Director: completely filled in by the it	edical C	29a. Certifier 1 Certify (Check only 2 Medica	ing Physician: To the I Examiner: On the ba and man	asis of examina	wledge, deat tion and/or in	h occurred a vestigation,	at the tim in my op	ne, date ar pinion, dea	id place, ith occurr	and due to the deed at the time,	cause(s) and r date and place	nanner as sta e, and due to	ited. the cause(s)
	o the	Me	29b. Signature and title of certifi				29c.	. License	number			29d. Date sign	ned (Month, D	Pay, Year)
			Daniela 1	1. Ch.	lan. 1	M	)	0	416	67		6	170	٠ نــ
L	H-4+1		30. Name and address of person	n who completed caus	e of death (Item	1 23a) (Type,	^		E 130		y 103	-100 K	17:0	ND
	Sta Regist		31. Date filed (Month, Nea	0 000 4 32. R	edistrar's Signa	iture			, ,	VI	- 10-	, ,		V 4

1				For State Registrar	State of I	Marylan	-	artmen			and M		giene Reg. No.	2001	21150	,
DREIN LEE KENT    Power   Powe				1. Decedent's Name (First, Middle	le, Last)									Year	3. Fime of Death	1
## Security (Control of Death   Proceeding For Interest   Proceding For Interest   Proceding For Interest   Proceding For Interest   Proceding For Interest   Proceeding For Interest   Proceding For Interest   Proceding For Int				DARIN LEE	KENT								22		4:00 p M	
Second Procession   Control	>			4a. Facility Name (If not institutio	n, give street and numb	er)		4b. City,	Town, or	Location o	of Death					
Transpare   Tran																_
Document   Document												8. Date of Bir	th Y O'-7'1	9. Birthp	lace (State or Foreign	
10.5 Shade   10.5 Cory   10.		Director	}				33 113.					01/01/	1971	1110.	Lana	_
The content of the		and and	}		,	10c. Cit	y, Town or Lo	cation				····		1	0d. Inside City Limits	_
The content of the		Mary	ğ	MD Worce	ster	Poo	comoke	City							1 ŽYes 2 ☐ No	
The content of the		1 the	rec						Code				10g. Citize	n of Whal Cour	ntry?	_
The content of the		38 o	<u>_</u>	904 Walnut Str	eet			218	51					USA		
The content of the		deatl	nera	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13.	Was Deced	tent of His	spanic Orig	gin? (Sp	ecify Yes or No	- 14.			_
The content of the	ဖွ	after or ite	교		ried 1 ☐ Yes 2	<b>Z</b> No	1				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	t mount, oton,	S		010.	
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The content of the	7	72 h "netu	ete	15. Deceder (Specify only highe	nt's Education est grade completed)		/Give	kind of wor	rk done d	lurina mosi	t of work	ing	16b. Kind	of Business/In	dustry	
The content of the	12	within ane. than	E E		College (1-4	or 5+)	_	DO NOT US	o remed	,			Const	tructio	n	
20. Larry D. Kentt    Table Information   Type, Print    190 Mailing Address (Sireet and Number of Park Address (Sireet a	2	filed Hygi ther int,			Last)		Labor			18. Mothe	r's Nam	e (First, Middle,				_
Approximate and Deposition (Park of June 28) (2004 Columbus, Indiana 2005 Columbus, Indiana	ano	d be intal			,,					Lind	la Si	itton				
Approximate and Deposition (Park of June 28) (2004 Columbus, Indiana 2005 Columbus, Indiana	<u></u>	should mark matte	۲		ship (Type, Print)		19b. Maili	ng Address	(Street a				er, City or T	own, State, Zip	Code)	
Approximate and Deposition (Park of June 28) (2004 Columbus, Indiana 2005 Columbus, Indiana	Z	lth ar 27 is r treu		Larry D. Kent (	father)		904 W	alnut	St.	, Poc		ce City	, MD 2	21851		1
23. Part I. Effect the disease, or completeions that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the cause (Final disease or completeions that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the cause (Final disease or completeions that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death of the d	ē,	s 1 au f Hea item othe		20a. Method of Disposition		20b. P	Place of Dispo	sition (Nan	ne of ther place	g)		Date	20c. Loca	tion - City or To	own, State	_
23. Part I. Effect the disease, or completeions that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the cause (Final disease or completeions that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the cause (Final disease or completeions that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death of the d	Ë	Page sent c nt: If ry or				<sup>ate</sup> Myer Reco	s Funera 1 & Jewe	il Servi	лœ æl		June	28, 20	04 Co	lumbus,	Indiana	
23. Part I. Effect the disease, or completeions that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the cause (Final disease or completeions that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the cause (Final disease or completeions that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death of the d	a Ei	mit. partrr porte y inju		21. Signature of Funeral Service	Licensee	1 4/1/20										
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the cause (Final increase) and the cause of the cause (Final increase). The cause of the cause (Final increase) and the cause of the cause (Final increase). The cause of the cause (Final increase) and the cause of the cause (Final increase). The cause of the cause (Final increase) and the cause of the cause of the cause (Final increase). The cause of the cau	8	88 = 8	17	Muchael 1.	Dean			03 Li	nden	Ave.	Po	comoke	City	MD 21	851	
The station of the				23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that cau t only one cause on eac	used the deat th line.									Approximate Interval Between	
Sequentially list conditions, any, leading to emmediate causes. Each Underfying any, leading to emmediate causes. Each Underfying that initiated events a sping of the past 12 months?    FEMALE 23b. Was decedent pregnant in the past 12 months?   Question of the past 12 months?	33	Physician	8 (2)	Immediate Cause (Final disease or condition	5	tramul	ation	due	to V	and	na				Onset and Death	
Sequentially list conditions as consequence of):    Sequentially list conditions are stated.   Sequentially lis	C	/Medical			Due to (or	as a conseq	uence of):				)					
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C.H.2 PO Ecorroll St., Salisbury, MD 21801				30. Name and address of perso	n who completed cause	of death (Iter	m 23a) (Type,	Print)	112,	/		1	9/			7
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Registrar JUN 2 3 2004 December 10. Appendix				31. Date filed (Month, Day, Yea JUN 2	3 2004 32.	gistrar's Signa	ature d	barde	,							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Day Year CHARLOTTE AUGUSTA LEGG Tune 2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death E O S + TO N

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) memoria bo 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 ☐ M 2 🗶 F Director 220-28-0847 72 MAY 13, 1932 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 ☐ Yes 2 X No MD QUEEN ANNE'S CENTREVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Items 23e 1309 HOPS ROAD 21617 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after of and Menta! Hygiene.
Is marked other then "naturel", or Iter Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 ☐ Yes 2X No Baltimore, Maryland 21215-003 Specify WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 OWNER/OPERATOR LIQUOR STORE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM MYERS CONLEY 2 **ELVA SEE** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 Is BONNIE LEGG THOMAS/DAUGHTER 316 MELVIN AVE., QUEENSTOWN, MD permit. Pages 1 and Department of Healt Important: If item 2: any njury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) KINGSLEY CEMETERY 06/11/2004 CHESTER, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Grady Immediate Cause (Final Physician ary thria disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner botension Hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events Examiner o or as a consequence of): The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. physician Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9☐ Unknown 9 Unknown Š signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed prosi 1 ☐ Yes 2 ☐ No 3 Probably **4**✓Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 50 1 ☐ Yes ≥ No Division of Vital 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After 1 XNatural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAKSHMIC VAIDYANATHAN M.D., 219 S. WASHINGTON STREET, EASTON, MD 32. Registre's Signature State Registrar

			Please	e Type or Print ir	n Black in	delible Ink.	Ensure A	II Copies	Are Legi	ble.	
			For State Registrar	State of Maryl		artment of F			giene	11.	21161
			Decedent's Name (First, Middle, I	Last)				2. Date of Dea	ath	14	3. Time of Death
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	Exami		4a. Facility Name (If not institution, g			4b. City, Town, o	Location of Death		4c. County		J. 40 AM
			Salisbury Nursin	g and Rehab Ce	enter		Salisbur	y, Md.	Wicom	iico	
	Funeral Director		5. Social Security Number 6 211-28-3392	. Sex 7. Age (In )	vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day April	29,193	9. Birthpl Count	ace (State or Foreign ry) W Jersey
	pu		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	nantina					
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	filed within 72 hours after death with the Maryland Hygiene ther than "naturel", or items 23a or 28a-f show ther than "naturel", or items the rodified at	Director	MD Talbo	t E	aston	10f. Zip Code			10g. Citizen of V	Mhat Causi	
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ဗ္ဗ	ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give^ Year or Dates:		1 ☐ Yes 2 🖟 No	Specify:		Specify	Whi	te
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and	be fi	Be	17. Father's Name (First, Middle, La not availabl	•			18. Mother's Nam	e (First, Middle, 'ailabl		10)	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If I term 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Evant nerminal termolified at	5	19a. Informant's Name/Relationship		40h M-00						- 131
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Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUN 18 2004

1346 S. Division St.Suite, Salisbury, Md.21804

John E. Lord 04-03941 RJ

-03	3941		State of Maryland / Dep	artment of Health and	Mental Hygid	ene	
			1- State Registrar AMEND ITEM #8 PER FR G833 7/26	rtificate of Death		1. NO. O O L	21162
air	Physic	an	Decedent's Name (First, Middle, Last)  Tohn, Edwond, Lond		2. Date of Death Month	Day Year	3. Time of Beattr
	/Medi Examir		John Edward Lord  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deal	June 15	4c. County of Dear	0020 A.™
	Lxaiiii	ICI	Prince George's Hospital Center	Cheverly		Prince Ge	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday			108/ 9 Birt	hplace (State or Foreign
	Director		220-11-5690	Months Bays Hours Ivini	May 13,	2 <del>004</del> Mar	yland
	laryland show		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	the Man 28e-f sh	tor	MD Anne Arundel Co. Lothian				1 ☐ Yes 2 No
	ath with the Maryland 23a or 28e-f show ust be notified at	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	untry?
	ath 23		172 B. Street	20711		U.S.A.	
920	after or Ite	by Funeral	11. Marital Status  1 Narital Status  1 Narital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Nes 2 No No If Yes, Give Yes, Gi	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
2-0		Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation	16	Sb. Kind of Business/	Industry
21	vithin ne.	nple	Elementary/Secondary (U-12)   College (1-4or 5+)	wind of work done during most of wo DO NDT use retired)			
2	be filed within 72 hatal Hygiene. id other than "netuevent, It e Madical		12 Elec	etrician		Local Uni	on #26
and	ould be f Mental F arked of atic eve	o Be	John Lord	Grace	ne <i>(First, Middle, M</i> a Jones	uden Sumame)	
Maryland 21215-0036	SPEE	To		ng Address (Street and Number or Ru		City or Town, State, 2	(ip Code)
	and 2 alth a 127 is 8r trei			B. Street, Lothia			
ore	of He of He item		20a. Method of Disposition 20b. Place of Disp			c. Location - City or	Town, State
Ĕ	Pag Iment tent: I		`4 □Donation 5 □Other (Specify) Lee Crema			linton, M	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is eny injury or other tree 80ce.		Michael W. Lee	2. Name and Address of Facility $^{ m LCG}$	yland Blvd	l., Owings	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between
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<b>Q</b>	res that igned b be deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds	w require been sig should b	ed b			1 ☐ Yes	3⊿No 3□Pro	bably 4 Unknown
I Records,	The larate has	Completed			24a Was an autopsy performed	d? prior to co	opsy findings available completion of cause of
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		th (Check only one)		
of \	phys this al dii	2	1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☑ XER/Outpatied 27. Manner of Death 28a. Date of Injury 28b. Time of		ome 5 Residence		fy)
	ling After fune	Certification:	1 □Natural 5 □ Pending (Month, Day Year) Injury	f 28c. Injury at Work?  A-M 1 □ Yes 2 □ No	* ES Value	injury occurred a diviver st	nch
Division	Attending er death. rector; After by the funer	ifica	3 Suicide 6 Could not be determined 28e. Place o Injury - At home, farm, str		28f. Location (Stree	r vehicle It and Number or Run	al Route Number 🔈
ă	s after	Sert	4 Homicide determined building, etc. (Specify)		City or Town, S Rt 231 at	itate)	are 1 andle
	To the Hospitel or Attence within 24 hours after death To the Funerel Director; completely filled in by the	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occur	and due to the caus	e/s) and manner as	Hug Nesville
	To t withi To tl		29b. Signature and title of certifier  Lawha 3 Hearberg MD	29c. License number  OCME	J	Date signed (Month, une 16, 20	004
	2		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) 111 Penn Street	, Baltimo	re, Maryla	and 21201
	Sta Registr	te ar	31. Date filed (Month, Day, Year) 32. Registres Signature JUN 1 8 2004   Screen	Sporte			
				7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. C. 2. Date of Death Decedent's Name (First, Middle, Last) Larkin Q. M **Physician** h /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, NOV 11, Birthpface (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🛛 F 1964 39 Yrs. Maryland 217-94-4511 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 → No Director Huntingtown MD Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 238 20639 USA permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "natural", or items 23s eny injury or other traumatic event, the Madical Examinationals. 510 Marleyrun by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 M No ff Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: lore, Maryland 21215-0036 Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Colfege (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stina Rebecca Linkous ပ Arnold Creasey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20639 510 Marleyrun, Huntingtown, MD Brian D. Larkin, spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Memorial Gardens 06-22-04 Dunkirk, MD So. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A., Owings, MD 20736 653 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition DOUL Physician Bleeding Intra evanual resulting in death) /Medical Due to (or as a consequence of): **Examiner** intracranial Increased Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Attending Physician: The law requires that the death certificate be executed Brainstem herniation and Due to (or as a consequence of): vision of Vital Records, P.O. Box 68760, the attending physician Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year Į Month Day 5 Other (specify) JYes 2 □ No director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Inknown 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification; To ihis After this funeral of 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No M hours after death. uneral Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide ŏ within 24 hours a To the Funeral F o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 June, 17 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

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Wolfe

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32. Registr

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31. Date filed (Month, Day, Year,

Baltimore, mD

			-		aryland / Dep			•	_	
			1 - For State Registrar	Otato of M		ertificate of			100 mg	21161
			1. Decedent's Name (First, Middle, La	ist)				2. Date of Death		3. Time of Death
	Physici /Medi		Helen Elizabeth	LAMBERSON				June	IS 2004	5:17 P M
	Examir		4a. Facility Name (If not institution, given	·		4b. City, Town,	or Location of Death	ı	4c. County of Death	1
			Washington Count				gerstown		Washingt	
	Funeral Director		5. Social Security Number 6. S 212-14-6705	Sex 7.Ag 1 □ M 2 📉 F	e (In yrs. last birthda) Yrs.	Months Day		(Month, Day, Y	(ear) 9. Birth	nplace (State or Foreign untry)
			Usual Residence of Decedent		84			March 12	! 1920 Peni	nsylvania
	rylan ihow		10a. State 10b. County		10c. City, Town or	_ocation				10d. Inside City Limits
	Ba-f s	cto	Maryland Washin	gton	Willi	amsport				1 ☐ Yes 2 🕅 No
	with th	Funeral Director	10e. Street and Number			10f. Zip Code		10g	g. Citizen of What Cou	untry?
	s 23e	eral	17035 Virginia A	1	5	217			U.S.A.	
	iter de itam	Inne	11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Armed Forces? 1 Tyes 2X		If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
93	urs a	þ	3 XWidowed 4 □ Divorced	ff Yes, Give Year or Dates:		1 ☐ Yes 2 N	o Specify:		Specify:	White
21215-0036	d within 72 hours after death with the Maryland giene. Ir than "natural", or itams 23a or 28a-f show It e Madical Examitret must be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Dec	edent's Usual Occi	upation	ting 16	b. Kind of Business/fr	ndustry
2		uple	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retir	e during most of wor ed)	A#19		
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and	TI - U 0	Be c	Oscar Edwin Litt					ne <i>(First, Middl</i> e, <i>Ma</i> Elizabeth		
Maryland	2 should be and Mental is markad a	T <sub>o</sub>	19a. Informant's Name/Relationship (		19b. Mai	ling Address (Stree	-		City or Town, State, Zi	in Code)
<u>@</u>	2 4 E B		Mary Sanner - Da			6 Wayside		derick, M		p 00de)
Baltimore,	ss 1 and 3 of Health item 27 other tr		20a. Method of Disposition		20b. Place of Disp			-	c. Location - City or T	own, State
ij	permit. Pages: Department of H Important: If ite any injury or ot		1 XBurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif		Cedar La		· 1	./04 н	agerstown,	Maryland
alt	permit. Departr Importa any inj		21. Signature of Funeral Service Licer	1See		Name and Add			neral Home	
ш	20229		COM	1 /w	mus				stown, Md.	21740
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	offications that caused one cause on each li	the death. Do not en	nter the mode of dy	ring, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
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Вох 6	ding p	Physician/Med	IF FEMALE:	22a If you gutteeme	of average.					
	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetaf death 3	Ectopic pregnanc	су		23d. Date of deliver	ery Day Year
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	es that the death certific igned by the attending p be detached for use as	by P	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying cause g	iven in Part	23e. Did tobac	co use contribute to the	he cause of death?
g	w require been sig should b	ed b	hypertension	ch	ranizab	structus	2 pilmon	1 ☐ Yes	10 No 3 Prot	oably 4 DUnknown
Records,	aw requas been 2 should	Completed	Oftenanosis				Liseage	24a. Was an	24b. Were auto	ppsy findings available
	sician: The law certificate has b irector, page 2 s	Com	hypothyroddish					autopsy performed 1 ☐ Yes	d? death?	impletion of cause of
Division of Vital	cian: ertific ector,	Be (	25. Was case referred to medical examiner?				26. Place of Deal	h (Check only one)		
<u></u>	physic this c	<sup>C</sup>	1 ☐ Yes & No	Hospital: Inpatie		III 3 DOA		ome 5 Residenc	e 6 Other (Specif	(۶)
UC.	Jing F	lon	27. Manner of Death  S ☐ Pending	28a. Date of Injui (Month, Day	Y Year) 28b. Time of Injury	Wo	ork?	28d. Describe how i	n <sub>f</sub> ury occurred	
<u>s</u>	death death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be	9	ury - At home, farm, si		]Yes 2□No	28f Location (Stree	t and Number or Rura	al Pauta Number
2	after after i Dira	Certification:	4 Homicide determined	building, etc	c. (Specify)			City or Town, S	tate)	ar route rannor,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funarai Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.		29a. Certifier Certifying Ph	ysician: To the best of	of my knowledge, dea	th occurred at the t	ime, date and place,	and due to the caus	e(s) and manner as s	tated.
	tha H in 24 tha Ft pletel	Medical	one)	niner: On the basis of and manner sta	examination and/or in	vestigation, in my	opinion, death occur	red at the time, date	and place, and due to	the cause(s)
	To To To To To To To To To To To To To T	2	29b. Signature and title of conflier	1			se number		Date signed (Month,	
	10		- We	12)		04	8940		16-16-20	104
~	pH.		30. Name and address of person who wife Kutzera, n	Completed cause of de	eath (Item 23a) (Type	Print)	Hoppics	2 2	36-16-20 A 21742	)
	Sta	te	31. Date filed (Month Phy Year)	1004 32. Pegistra	ar's Signature	NUC	10000018	Jun Juli	N 41/70	
	Registra		OUN TO 2	July Spece	ar's Signature	out				

			For State		State of	Maryla	-					lental Hy	giene		
		_	1 - State Registrar  1. Decedent's Nan	no (Eirst Middle	. fact)		Ce	rtificate	e or i	Death			Reg. No	104	21155
	Physici	an			n Watkins	Linki	ne					2. Date of De Month	Day	Year	3. Time of Death
	/Medio						113	45 00	T			June	21	2004	0245 <sup>M</sup>
1	Examir	ier	_		give street and numb				Iown, or	Location of	of Death			nty of Death	
			5. Social Security		ng and Re		itation last birthday)	Ctr.		ow H		8. Date of Bir	Wor	ceste	r
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Baltimore,	permit. Pages Department of It Importent: If ite any injury or of				3 Removal from Sta	110	cemetery, crei			· .	6-21-	.04 Ι	Frankf		
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Ba	Depa Depa Impo any ii			11	11/3/	41.						ral Hom			St.,
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			30. Name and add	ress of person 4	no completed cause of	of death (Ite-	m 23a) (Type		,	_					1
H.	4		1604-	Mar	Ket St	. 40aur (1101	PO CO	7000	Ke,		11	218	51		
	Sta	te	31. Date filed (Mor		32 <b>4</b> Regi	strar's Signa	ature /	~?	/						
	Registr			JUN 22	2004	aa A	or Ap								

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Lipscomb Jun 29, 2004 Robert 8:15 am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cumberland Villa Nursing Home Cumberland Allegany 5. Social Security Number If Under 1 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **№** M 2□ F Months Hours Days 213-16-9206 Feb 27, 1913 MD Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Allegany Cumberland 1 ☐ ¥es 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 907 Bedford Street 21502 USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No IXYes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: white 3 Widowed 4 Divorced WWI 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance man self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Albert Grant Lipscomb Daisy Wise Lipscomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Wempe Drive Nancy Snyder Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rodeheaver Cemetery 7/2/2004 MD Oakland 22. Name and Address of Facility Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service Licensee ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. 108 Virginia Avenue; Cumberland, MD 21502 Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₽No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Physician/Medical Examiner for use Completed by Medical Certification: To Be

**Physician** 

/Medical

Examiner

MD

Director

Funeral

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Completed

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**Funeral** 

Director

tem 27 is marked other then "neturel", or items 23a or 28e-f show other treumatic event, the Madical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "--- ery injury or other treums"--- and injury or other treums"--

or Attending Physicien: The law requires that the death certificate be ours efter death.

eral Director: After this certificate hes I filled in by the funeral director, page 2 s Hospital 6 To the Hospital within 24 hours e To the Funeral C completely filled

Division of Vital Records, P.O. Box 6876

**Physician** /Medical

Examiner

State Registrar

31. DSunimGupta ... M.D.

29b. Signature and title of certifier

4 ☐ Homicide

(Check only one)

29a. Certifier

32. Registrar's Signatur 625 Kent Avenue Cumberland MD 21502

The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0033280

29d. Date signed (Month, Day, Year)

June 29, 2004

JUL 07 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Physici /Medi		Decedent's Name (First, Middle, L     Roscoe	Lonnie	Mart			2. Date of De Month June	27, 20	Year 004	3. Time of Death
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le-f show	ctor	10a. State 10b. County Maryland Cecil		10c. City, Town or Lo Port D					100	d. Inside City Limits
23a or 26 ust be no	al Directo	10e. Street and Number  11 Wild Flower W	lay		10f. Zip Code 21904			10g. Citizen of Unite	What Countr	•
Hygiene. uther then "natural", or Itams 23a or 28e-1 show ent, the Modical Experiment must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:	io	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or No arto Rican, etc.)	- 14. Rai Bla Specif	ce - American ick, White, et y: Whit	c.
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Health and tem 27 Is m other traum		19a. Informant's Name/Relationship  JoAnn Meadows/Da  20a. Method of Disposition		11 W	ild Flowe	er Way,	Port Depo		219	04
Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then 'natur any injury or other traumatic event, ITEM CICE. Once.		1 ☒ Burial 2 ☐ Cremation 3 ( 4 ☐ Donation 5 ☐ Other (Spec.) 21. Signature of Fuheral Service Ace	ify)	20b. Place of Disponentery, creating Gilpin Mana	or Memorial 2. Name and Addre	Park July		Elkton		
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ate ha	Completed						24a. Was a autop perfor	med?	death?	y findings available tetion of cause of ☐ No
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within 24 hours after death.  To the Funerel Director: A completely filled in by the fu	Certificat	2 Accident Investigation 3 Suicide 6 Could not to determined	De Blace of Injur	ry - At home, farm, str (Specify)			28f. Location (S City or Town	treet and Numb n, State)	er or Rural R	oute Number,
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느느으	Σ	29b. Signature and title of certifier	11 /	1.	29c. License		2	9d. Date signed		
To th	1	30. Name and address of person who	H. How	ore M		D42800		JUNE 27	7, 2004	1

unpend item#23a,27,28a-f,PER ME,G833,7/8/04eg Michael Terrance Mangan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-03991 Amend Item #25 tate of Maryland Construction #25 tate of Maryland Construc 1 - For A State Registrar RJ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 **Physician** June 17, 0847 A. M Michael Terrance Mangan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 910 Kingsbridge Terrace Mt.Airy Carroll County If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 53 077-50-2230 Yrs December 30.1950 Amityville, New York Director Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23s or 28s-f show other traumatic event, the Nedical Examinar must be notified at 1 ☑ Yes 2 ☐ No Directo Maryland Carroll Mount Airy the 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 910 Kingsbridge Terrace 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filad within 72 hours after and Mental Hygiene. Is marked other than "natural", or Ita 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Handicapped Handicapped ARC of Carroll County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis P. Mangan Edna M. O'Brien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parmit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. Mavoureen Mangan/ Sister 910 Kingsbridge Terrace/Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXturial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State June 22, 2004 East Farmingdale, New York Donation 5 Other (Specify) St. Charles Cemetery 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licenses 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): attending physician Box 68760 Physician/Medicai as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Pa 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Division of Vital **Y**es 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6X Other (Specify) Scene 2 1 XYes 2 ☐ No 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After 1 Certification: 5 Pending 1 Natural found 6/17/04 found 8:25a death. 1 TYes 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 17, 2004 OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State works Registrar JUN 2 8 2004

			For Stata Ragistrar	State of M	Maryland		artment rtificate					Reg. No. (	004	21169
	Physicia	an	1. Decedent's Name (First, Middle, L								<ol><li>Date of De Month</li></ol>	ath Day	Year	3. Time of Death
	/Medic			Paul J.		<u> </u>					June	20	2004	3:12 P M
	Examin	er	4a. Fecility Name (If not institution, g		er)				Location o				ounty of Death	
			3000 North Ridge 5. Social Security Number 6.		Age (In yrs. las	t hirthday)	If Under		ott If Under:		8 Date of Bir		Ioward	place (State or Foreign
	Funeral Director		214 14 9423	10 <b>X</b> M 2□ F	82	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 1-25-			place (State or Foreign ntry)
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	show 1 at	_	10a. State 10b. County		10c. City, 7	Town or Lo	cation							10d. Inside City Limits
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	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show than Madical Examinar must be notified at	Funeral Director	1 Never Married 2 Married	Armed Force	s?	10.	If Yes, spec	ify Cubar	n, Mexican	, Puerto F	lican, etc.)		Black, White,	
036	urs al	by	3 XWidowed 4 □ Divorced	If Voc Circo	- s: 1942 <b>-</b> 4	5	1☐Yes 2	No No	Specify:			S	рес <i>ify:</i> W	hite
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2	filed w Hygier other th	S	12 17. Father's Name (First, Middle, La:	nel		Lol	obyist		19 Motho	eta Nama	(First, Middle	ACW		
and	ould be filed v Mental Hygie arked other t atic evant, In	Be	Guiseppe Mignini								Laure			
Maryland	should ind Men s marke umatic	ဥ	19a. Informant's Name/Relationship			19b. Maili	na Address	(Street a					own, State, Zij	n Code)
S	and 2 sho eatth and n 27 is m		Paul J. Mignini,										21093	,
ē,	s 1 and 7 f Heatth itam 27 other tr		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. Plac		osition (Nam				ite		tion - City or T	own, State
Ē	Pages nent of int: If its iry or o		¹X Burial 2 ☐ Cremation 3  14 ☐ Donation 5 ☐ Other (Special Control C				Nat'			6-24-	2004	Balt	imore,	MD
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene.  Important: If itam 27 is marked other than "natural; or itams 23a or 28a-f show any injury or other traumatic evant, the Madical Examinar must be notified at once.		21. Signature of Funeral Service Lic	ensee 010	M01044	2	2. Name and	d Address	s of Facilit	y Harr	уH. W	itzke	's Fami	ily FH Inc.
<u>m</u>	89789		hom Colom	s- Attake		41	L12 O1	d Co	1umb	ia Pi	ke Ell	icott	City,	MD 21043
г			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus ly one cause on each	sed the death. I line.	Do not en	ter the mode	of dying	, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	_a Pu	Imona	7	Fibr	-051	۷					Yeurs
b	/Medical Examiner		resulting in death)	Due to (or	as a conseque	of):								
	MAN	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequer	nce of):								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or Injury) that initiated events	8										
oʻ	be executed sician and burial-transit		resulting in death) Last	C. Due to (or	as a consequer	nce of):								
8760,	he ye	icai		d										
99	death certifica attending ph d for use as t	Physician/Medi	IF FEMALE:											
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal de	eath 3[	Ectopic pre					230	<ol> <li>Date of deliving</li> <li>Month</li> </ol>	ery Day Year
<u>.</u>	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant 9□ Unknown	t at time of deat	in 5L	Other (spe	эспу)						,
<u> </u>	The law requires that the ste has been signed by th page 2 should be detache		Part II. Other significant conditions	contributing to death	n but not resulti	ng in the u	ndertying ca	use give	n in Part I.		23e. Did t	obacco use	contribute to t	he cause of death?
ds,	uires n sign uld be	d by									1 🗆 '	Yes 2 1	No 3 Prol	bably 4 Unknown
Record	aw requir ts been s 2 should	Completed									24a. Was	an 2	24b. Were auto	ppsy findings available
	The lav te has age 2	mo									autor perfo	rmed?	death?	mpletion of cause of 2□ No
Vital		Be C	25. Was case referred to medical						26. Place	of Death	(Check only o			
<u>-</u>	Physic this ce al dire	Tof	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpa	atient 2 EF	VOutpatier				rsing Hom	e 5. <b>Z</b> Resi	dence 6	Other (Specia	fy)
ם		on:	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Ir (Month, I	njury 28 Da <i>y Year)</i>	8b. Time o Injury		Bc. Injury Work			Bd. Describe	now injury a	ccurred	
Sio	Attanding or death.  ector: After by the funer	cat	2 Accident investigat 3 Suicide 6 Could not	he	Inius Athon		M		′es 2 🔲 l	-	of Location (	Stroot and A	lumbar or Pur	al Route Number
Division of		ertification;	4 Homicide determine		Injury - At home etc. (Specify)	e, iann, sti	reet, factory,	, опісе		2	City or To	vn, State)	umber or Aure	al Route Number,
_	spital ours a narai	O	29a. Certifier 1 XCertifying	Physician: To the be	st of my knowle	edge, deat	h occurred a	at the time	e, date an	d place, a	nd due to the	cause(s) an	d manner as s	stated.
	To the Hospital or Attanvillin 24 hours after deatl To the Funaral Director: completely filled in by the	Medical		aminer: On the basis and manner	of examination									
	To the within :	Me	29b. Signature and title of certifier	1			29c.	License	number			29d. Date s	igned (Month,	Day, Year)
			1/2/e	h	m		D	46	120			June	23, 20	04
/	920		30. Name and address of person wh				Print)							
_	1000		T De Leon	10724	Little	Port	went	PK	wy,	Co	/unbis	*,	2000	1204
	Sta Registr		31. Date filed (Month, Oay, Year)  JUN 2 3	2004	Liffle strar's Signatur	× A	bert)		0					

			1 - For State Registrar	State of Ma	aryland		artment of H		i Mental Hyg	iene	L 21170
	Dhomini		1. Decedent's Name (First, Middle, La	st)					2. Date of Dea	h	3. Time of Death
1	Physici /Medio		Mary Patr	icia	Mulv	aney			June 16	,2004	10:07 a м
	Examir		4a. Fecility Name (If not institution, giv	e street and number)			4b. City, Town, or	Location of De	ath	4c. County of E	Death
			6600 Jupiter Dr				Huntin			Calve	ert
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	n (Month Day	Year) 9.	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		84	115.			Dec. 13	,1919 Ma	assachusetts
	land ow		10a. State 10b. County	-	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Many -f sh	to	Maryland Calvert	_	Hur	ntingt	own				1 ☐ Yes 2X No
	r 28s	Directo	10e. Street and Number		-		10f. Zip Code		1	0g. Citizen of Wha	t Country?
	th wit	aiD	6600 Jupiter Dri	ive			206	539		U.S.A	٨.
	ems ems	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	ver in U.S.	13. V	Vas Decedent of His	spanic Origin?	(Specify Yes or No- erto Rican, etc.)		American Indian,
36	or It		1 Never Married 2 Married	1 □Yes 2 XN If Yes, Give	lo	1	☐ Yes 2 No	Specify:	erto racari, etc.)		Vhite, etc.
8	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examiraer must be notified at	d by	3 XWidowed 4 □ Divorced	Year or Dates:						Specify:	white
15-	n 72 "nat	Completed	15. Decedent's Ed (Specify only highest gra			(Give I	ent's Usual Occupa kind of work done di DO NOT use retired)	uring most of w	vorking	16b. Kind of Busine	ass/industry
712	with iene. thar	omp	Elementary/Secondary (0-12)	College (1-4or 5	+)	secre				J.S. Gove	rnment
D	i Hyg other	ø	17. Father's Name (First, Middle, Last)			DCCIC		18. Mother's N	ame (First, Middle, M		TIMEIL
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Insportent: If item 27 is marked other than "natural," or Items 23a or 28a-f show any injury or other treumatic event, Its Medical Examinar must be notified at once.	To B	David	Landr	_				garet		cCormick
Mai	alth and 2 st		19a. Informant's Name/Relationship ( Susan Marie Mulva						Rural Route Number, wings, MD		'e, Zip Code)
ore,	of He of He litem		20a. Method of Disposition	ID	20b. Plac	e of Dispos	sition (Name of atory or other place	)	Date	20c. Location - City	or Town, State
Ĕ	Pag nent ent: if ury o		1 😾 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify		1		National		6,2004	Arlingtor	n, VA
Baltimore,	permit. Departi Import any inj once.		21. Signature of Funeral Service Licer	See /			Name and Address				
_	205 29		William K	. Oron					me P.A., C		D 20736
The state of	Pnysician /Medical Examiner	J.	23a. Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a	e. Talic I consequer	nce of):	NCEL -			st,	Approximate Interval Between Onset and Death
	ted nsit	nine	Cause (Disease or injury	Due to (or as a	consequer	ice oi).					
Ć,	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequer	nce of):					
8760,	ysicia ysicia	dicai		. d							
9	rtifica ng ph as th	Medi	IF FCHALC								
.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknowh	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 🗌 Fetal de	ath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
S,	es that igned b	by PI	Part II. Other significant conditions of	ontributing to death bu	t not resultin	ng in the un	derlying cause giver	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ord	w require been si should b								1 ☐ Ye	s 2 No 3	Probably 4 Dunknown
Vital Record	The la	Completed							24a. Was an autopsy perform	prior	
Ę	Physician: r this certifice ral director, p	o Be	25. Was case referred to medical examiner?	Hospital:			Other		eath (Check only one		
of	Phy or this oral d	$\vdash$	1 Yes 2 XNo 27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury		Outpatient  Bb. Time of	3 DOA 28c. Injury a	4   Nursing	Home 5 X Hesider 28d. escribe how	nce 6 Other (S	pecify)
o	Attending ir death. ector: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	Work?	es 2 🗆 No		· injury occurred	
Division of	or Attending Phy after death. Director: After thi in by the funeral of	iifica	3 ☐ Suicide 6 ☐ Could not be determined	280. Place of Injul	ry - At home	, farm, stre	et, factory, office		28f. Location (Stre	et and Number or	Rural Route Number,
	spital or ours afte neral Dir filled in	Certification:	4 - Hormondo	building, etc.	(Зреспу)				City or Town,	State)	
		edical	29a. Certifier (Check only one) (Check only one)	ysician: To the best of liner: On the basis of and manner state	examination	dge, death and/or inve	occurred at the time estigation, in my opin	, date and place nion, death occ	e, and due to the car curred at the time, da	use(s) and manner te and place, and d	as stated. lue to the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier	$\cap$ $\cap$			29c. License	number	29	d. Date signed (Mo	onth, Day, Year)
			h shares	Tato			1	5906	./	Time	17 2nn4
	18		30. Name and address of person who death of D. L. I	completed cause of de	ath (Item 23	a) (Type, P	rint)	L 111	P	1/2 1	11) 20170
	Stat Registra	_	31. Date filed (Month, Day, Year)	7 2004 A	s Signature	K	South 1	FG ///	rince re	cascick	MD 20678
	310411		_				The same of the sa				

			For State Registrar	State of Maryla		artment of H		Mental Hygien	2001	21171
h	Physici		1. Decedent's Name (First, Middle Dorothy	e, Last) Brown		McDonald			ay Year	3. Time of Death 3:45 PM
į	/Medic Examin		4a. Facility Name (If not institution	n, give street and number) Care Center		4b. City, Town, o Bowie	r Location of Death		2004 c. County of Death rince Geo	rges
	Funeral Director		5. Social Security Number 212–12–9242		rrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea Apr. 19, 1	9. Birthpl County 917 Mary	lace (State or Foreign try) 1and
	Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince		City, Town or Lo	ocation			10	0d. Inside City Limits 1X1Yes 2 □ No
	or 28a	Funeral Director	10e. Street and Number			10f. Zip Code		10g. C	citizen of What Coun	try?
	s 23e	eral	1315 Paddock	Lane	nIIS 13	20716 Was Decedent of H	lispanic Origin? (S	necify Yes of No-	U.S.A.	an Indian
036	72 hours after death with the Maryland Instural', or Itams 23a or 28a-f show Jisal Examilinet met be invitted at	by Fun	1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? ned 1 ☐ Yes 2 Å No	10.5	If Yes, specify Cub	Specify:	o Rican, etc.)	Black, White, e	etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: if item 27 is marked other than "naturat", or Itams 23a or 28a-f show any injury or other traumatic evant, the Madical Examination at the malified at once.	Completed by	15. Deceden (Specify only highe Elementary/Secondary (0-12)	nt's Education st grade completed)  College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor d)	king	Kind of Business/Ind	
2	Hygier Hygier ther ti	CO	17. Father's Name (First, Middle,	Last)	Macr	ine Oper		ne (First, Middle, Maide	Manufactui on Surname)	cing
Maryland	Mental Mental rked o	To Be	William	Brown			Christ	ianna	Abı	rams
lary	2 shot and N is ma		19a. Informant's Name/Relations	hip (Type, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Number, City	or Town, State, Zip	Code)
e, E	1 and Health am 27 ther to		Clarence McDona 20a, Method of Disposition	20	b Place of Disno	sition (Name of		ie, Maryla Date 20c.	nd 20715 Location - City or To	wn, State
mor	Pages ent of nt: If it		1 ABurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from State Ma Specify)	<i>cemetery, cre</i> aryland Memorial	matory or other pla National Park	6/19	/2004 La	urel, Mary	yland
Baltimore,	permit. Departm Imports any inju		21. Signature of Funeral Service		2	2. Name and Addre	ss of Facility $\operatorname{Rol} olimits$	oert E. Eva ad, Bowie,		1 Home 20715
L	Pnysician		shock, or heart failure. List Immediate Cause (Final	r complications that caused the disonly one cause on each line.	leath. Do not en		ng, such as cardiad	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a cons						
	ted .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cleans of April 1997), that initiated events	b. Due to (or as a cons	sequence of):					
8760,	death certificate be executed e attending physician and id for use as the burial-transit	ical Exa	resulting in death) Last	Due to (or as a con:	sequence of):					
9	ntificating physics as the		IF FEMALE:				-			
O. Box	that the death certifics ed by the attending pt detached for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre  1 ☐ Live birth 2 ☐ F  4 ☐ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of delive Month	ry Day Year
rds, P.O.	Se us es	by	Part II. Other significant conditions of the A	ons contributing to death but not les Mellifly Stenosis	resulting in the u	Inderlying cause giv	en in Part I.		use contribute to th	e cause of death? ably 4 Unknown
Vital Records,	e law has b	Completed	Aontic	, Stenosis				24a. Was an autopsy performed?	prior to condeath?	osy findings available npletion of cause of
ital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medica examined?		/		26. Place of Dea	th (Check only one)		
of V	d S	ဥ	1 Yes 2 No 27. Mann of Death	Hospital: 1 Inpatient 2			4 🗀 Nuising F	ome 5 Residence		)
Ou	ding After fune	ation	1 Natural 5 Pendin 2 Accident investi		r) Injury	Wor	k? Yes 2 □ No	Zud. Describe now in	ary occurred	
Division	in Die	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ			reet, factory, office		28f. Location (Street a City or Town, Sta		Route Number,
	ne Hospital	edical (		ng Physician: To the best of my Examiner: On the basis of exam and manner stated.						
)	To the within 2 To the complet	W	29b. Signature and title of certifie	N Aflictor	00	29c. Licens			ate signed (Month, L	
			SALVADOR Syl		(Item 23a) (Type,	Print)	Cheve	rly mor	1 /md	
	Sta Regist		31. Date filed (Month, Day, Year	2004 32. Aegistrar's Si	ignature .	المال		,		
DE	IMH 17 Rev 1/2	001		-						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1 Decedent's Name (First Middle Last) 2. Date of Death Year **Physician** Herman Murrell JUNE 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner JOhns If Under 24 Hrs. 6. Sex 1 ☑ M 2 ☐ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Yrs. 238-60-4043 63 Director July 4, 1940 North Carolina Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Exertment he redified at 1 Yes 2000 Directo Maryland | Prince Georges Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 1507 Golf Course Drive 20721 U.S.A. death 1 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. 1 Never Married 2 X Married 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) High School Principal Education is markad other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Henry Murrell, TT Rickard ျှ Bonner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20721 permit. Pages 1 and 2:
Department of Health at
Important; If itam 27 is
any injury or other trau Elaine Murrell/ Wife 1507 Golf Course Drive, Mitchellville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Washington, 20a. Method of Disposition Date 1 

Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Oakdale Cemetery 6/28/2004 North Carolina 21. Signature of Funeral Service License 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Amapolis Road, Bowie, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal Acute Failure one month /Medical Due to (or as a consequence of) Examiner Metastatic Gastric one month Sequentially list conditions, if any localing to immunitate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 1X Yes 2 □ No To the Hispital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ₹ No 1 Minpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 KNatural 5 Pending 1 Yes 2 No investigation 2 Accident Director: 3 🗀 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To tha Funeral D 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. G 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) MD, PhD RE3-000 June 19,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH JORDAN, ND.PLD JUHNS HOPKINS HOSPITAL TOWER 110, DOCTORS LOWINGE, 600 NORTH WOLFE STREET, BAUTIMARE HOZIZBY State JUN 22 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:25 A<sup>M</sup> McGraw 2004 **Eleanor** June /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Somerford House Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 27,1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F 215-03-6660 Dec. **Director** Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examinar is ust be multipled at 1 ☐ Yes 2X No Director Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10116 Sharpsburg Pike 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🕅 No Specify: Specify: ð 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any liquy or other traumatic event, 900.8. 17. Father's Name (First, Middle, Last) Be Frank U.S. Baker Eleanor Amelia Dykes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19107 Cherry Tree Drive Hagerstown, MD 21742 Frank McGraw/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory | 6/20/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S.Mar 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONAR' IBROS15 YEARS Pmysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ned by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2□ No 1 ☐ Yes 1 🗌 Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) ASSIS 25. Was case referre o medical examiner? Other: 4 Nursing Home 5 Residence 6 Pother (Specify) FACILI 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Many er of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature mpleted cause of death (Item 23a) (Type, Print) HAGERS 32. Registrar's Signature State Registrar

			1 - For State Registrar		ryland / Dep.		lealth and M	lental Hyg	•	
	Physici /Medi		1. Decedent's Name (First, Middle,	M	ILLER			2. Date of Deat Month	L	3. Time of Death
	Examir		9	give street and number) .onal Hosp:		4b. City, Town, or Lau1	r Location of Death	8. Date of Birth		e Georges
	Funeral Director		220 - 26 - 6210  Usual Residence of Decedent  10a. State 10b. County	1 M 2 K	73 Yrs.	Months Days	Hours Min. Febru	ary 19	, 1931	9. Birthplace (State or Foreign Country) Maryland
	r 28e-f ehor	rector	,	Georges	Bowie	10f. Zip Code		10	Og. Citizen of Wh	10d. Inside City Limits 1 ☐ Yes 2 ▼ No nat Country?
ω	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show with jujury or other treumatic event, the Madical Exaculturit must be multified at once.	Completed by Funeral Director	2809 Sudberry  11. Marital Status  1 Never Married 2 Marrie	12. Was Decedent E Armed Forces?			ispanic Origin? (Spe n, Mexican, Puerto		USA	American Indian, White, etc.
Baltimore, Maryland 21215-0036	in 72 hours e n "naturel", o	pleted by	3 Widowed 4 □ Divorced  15. Decedent's (Specify only highest	Year or Dates:  Education grade completed)	16a. Dece (Give	1 Yes 2 No  dent's Usual Occupi kind of work done of DO NOT use retired	Specify: ation during most of worki	ng	Specify:	White
and 212	d be filed with ntal Hygiene ed other the	Be	17. Father's Name (First, Middle, L. Harry Benjami	/	)	cretary	18. Mother's Name	(First, Middle, N	faiden Sumame)	L Govt.
, Maryl	and 2 should salth and Me n 27 te mark er treumatid	To	19a. Informant's Name/Relationshi Paul Miller/S	o (Type, Print)	19b. Mailin 2809	ng Address (Street a Sudberi	and Number or Rura	Il Route Number,	City or Town, St	ate, Zip Code) L <b>5</b>
ltimore	iit. Pages 1. artment of He brient: If iten injury or oth		20a. Method of Disposition  1 Surial 2 Cremation 3  4 Donation 5 Other (Special Service Li	icify)	MAKE	y Memori	La1 6/24	/04	Waldori	ty or Town, State E, Maryland
Ba	Department of the post of the		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused t	he death. Do not ent	P.O. BOX	SECHOLS K 567 LA g, such as cardiac o	PLATA	,MD. 20	) 646 Approximate
	Physician /Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. <u>OVA</u> Due to (or as a	Consequence of):	CANO	in			Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	lical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a	consequence of):					
P.O. Box 6	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 54 hours elited death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	,
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Vital Rec	ysicien: The law is certificate has by director, page 2 sh	e Completed	25. Was case referred to medical					24a. Was an autopsy perform 1 Yes	ed? prid dea No 1	re autopsy findings available or to completion of cause of th? Yes 2000
Division of Vi	r Attending Physicie er death. rector: After this cert i by the funeral direct	sation; To Be	examiner?  1 Yes No  27 Manner of Death  Natural 5 Pending 2 Accident investiga		28b. Time of	28c. Injury Work	4   Nuising Hon		nce 6 Other	(Specify)
DIVIE	Hospitel or Atten 24 hours efter deat Funerel Director: tely filled in by the	il Certification;	3 Suicide 4 Homicide 6 Could no determin	28e. Place of Injurbuilding, etc.		•		City or Town,	State)	or Rural Route Number,
	To the Hospitel or within 24 hours efter To the Funerel Discompletely filled in	Medical	(Check only 2 Medical Example)  29b. Signature and title of certifier	aminer: On the basis of e and manner state	xamınation and/or inv	vestigation, in my op	number	d at the time, dat	e and place, and d. Date signed (A	due to the cause(s)  Month, Day, Year)
8	810		30. Name and address of person with 8343	3 3	uth (Item 23a) (Type,	Print) Isabe	ella Ma	rtir J	270	7
	Sta Registr	0.00	31. Date filed (Month, Day, Year)  JUN 2 3	2004 32. Rejistrar	s Signature	berks				· · · · · · · · · · · · · · · · · · ·

040			For State	State of Ma	-	epartme <i>Certifica</i>			and Ment		ene a. N2 0 0 4	21175
Г	Physici	an	1. Decedent's Name (First, Middle, La	_						ate of Death		3. Time of Death
	/Medic Examin	al	Bob  4a. Facility Name (If not institution, given	re street and number)	90	4b. Ci	Murph	Location o		ne 20		0941 P M
2	Examilia	Ę1	Southbound Route	301 @ Pier		W	aldor	£			Charles	
ľ	Funeral Director			Sex 7. Age 1 X M 2 □ F 50	e (In yrs. last birti	rs. If Und Month	er 1 Year Days	If Under 2 Hours	Min. (N	ate of Birth fonth, Day,	rear)	Birthplace (State or Foreign Country)
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location			DC	e. 22	, 1933 - Ma	ryland  10d. toside City Limits
	e Mary le-f sho	ctor	Maryland Charles			Wal	lorf					1 ☐ Yes 2 🛣 No
	death with the Maryland ms 23s or 28e-1 show rmust be notified at	al Director	10e. Street and Number 12208 Gillespie	e Cr.			tip Code 0601			10	og. Citizen of What U.S.A	
920	ours after el', or Ite	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ₩ bivorced	12. Was Decedent E Armed Forces? 1 \( \text{Yes} \) 2 \( \text{M} \) if Yes, Give Year or Dates:			edent of Hi ecify Cuba 2 No	ispanic Orig n, Mexican Specify:	gin? (Specify Y , Puerto Rican	es or No- , etc.)	Black, W	merican Indian, hite, etc. White
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Maryland 3	12 should be filed within hand Mental Hygiene. 7 Is marked other then "treumetic event, the Mes	To Be C	17. Father's Name (First, Middle, Last Bob Leo Mu						r's Name <i>(Fir</i> si Cy R.	Buck	laiden Sumame) ler	
Mary	d 2 sho th and I to me		19a. Informant's Name/Relationship ( Rosalie Pilkert	•		_					City or Town, State aryland 2	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 is marke eny injury or other treumetic once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	20b. Place of cemetery	-	ame of other place	e) Ji	ine 25,	2004 2	Oc. Location - City	or Town, State
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Division of	Jing 1. After fune	Certification: T	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	28a. Date of Injur (Month, Day	Year) 28b. Ti	me of jury PM	28c. Injury Work 1 🔲 \	at ?	28d. D	escribe how	v injury occurred an Struct	Ly two
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	To the Ho within 24 h	Medical	(Check only one) 2 Medicat Exal	miner: On the basis of and manner sta	examination and	or investigation	n, in my op	pinion, deatl	h occurred at t	he time, dat	te and place, and d	ue to the cause(s)
	Mil To		29b. Signature and title of confirer	Aux)	M		oc. License				d. Date signed (Mo.	
1	84		30. Name and address of person who	GAN	eath (Item 23a) (1	111		Street	t, Balt	imore	, Marylan	d 21201
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		•	1 _ State	State of	Marylan	•	rtment of H	lealth and M Death		ene g. Ng2	21176
			Registrar  1. Decedent's Name (First, Middle, Last)				imouto or i		2. Date of Deat	1	3. Time of Death
	Physicia		Florence	M	lae	McFa	adden		June 2	26, 2004	0020 A M
	/Medic Examin		4a. Facility Name (If not institution, give str	et and num	ber)		4b. City, Town, o	Location of Death		4c. County of Death	1
			Union Hospital				Elktor			Cecil	
	Funeral Director		5. Social Security Number 6. Sex 382-16-8821 1□ N	2 <b>X</b> ]F	7. Age (In yrs. i 81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 19	Year) 9. Birth Cor 1923 Penr	nplace (State or Foreign untry) nsylvania
	ס		Usual Residence of Decedent		40.00	-					
	arylar show	7	10a. State 10b. County Delaware Sussex			y, Town or Lo Rehobot	th Beach				10d. Inside City Limits 1 X Yes 2 □ No
	he M	Director	10e. Street and Number				10f. Zip Code		11	ng. Citizen of What Cou	
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	death	Funeral			dent Ever in U.	S. 13. y	Vas Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	ncan Indian,
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. is marked other then "naturel; or items 23e or 28e-f show eumatic event, the Maalfall Examiner must be mailfied at	by Fur	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Formal Test of T	2 📉 No ∋		f Yes, specify Cuba I □ Yes 2∑ No	an, Mexican, Puèrto Specify:	Rican, etc.)	Black, White	
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Maryland 21215-0036	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)					18. Mother's Name			
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ğ Z	s 1 and 2 should f Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type Nadine Deckman-Seco		hter		•	lve, Elkto		-	
<u>စ</u> ်	Health Health tem 27 other tre		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of			20c. Location - City or 1	Fown, State
ē	Pages nent of I ant: If its ary or o		1 🖾 Burial 2 ☐ Cremation 3 ☐ Rer '4 ☐ Donation 5 ☐ Other (Specify)	noval from S	iate	-	natory or other place Methodist	1	30, 2004	Cherry Hil	l, Maryland
Baltimore,	permit. Pages 1 an Department of Heal Importent: if item 2 any injury or other once.		21. Signature of Funeral Service Licensee	1 -	,	22 H;	. Name and Addre	ss of Facility  For Fune	erals, P	.A.	-
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۰			shock, or heart failure. List only one Immediate Cause (Final	cause on ea	ich line.	,, 50,10,011	1 . /	1			Interval Between Onset and Death
E	Pnysician /Medical		disease or condition resulting in death)	Pue to (	or as a consequ	uson off:	Tury to	11/4/6			x weeks
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89	ntifica ng ph as th	Medi	IF FEMALE:							T .	
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n	Jing F	ion	27. Manner of Jeath  1 Natural 5 Pending 2 Accident investigation	(Monti	of Injury h, Day Year)	Injury	Wor	k? Yes 2 □ No	200. Describe no	w injury occurred	
Division of Vital Records,	Attend death ctor: y the	fical	3 Suicide 6 Could not be	28e. Place	of Injury - At he	ome, farm, str	eet, factory, office			eet and Number or Rui	ral Route Number,
<u>S</u>	el or A s after i Dire d in by	Certification;	4  Homicide	buildin	ig, etc. (Specif	y)			City or Town	. State)	
	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical C	29a. Certifier Check only one) Certifying Physic (Check only one)	r: On the ba	sis of examina	wledge, death tion and/or inv	occurred at the tir	ne, date and place, pinion, death occur	and due to the ca	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the Howithin 24 I	Med	29b. Signature and title of certifier	and mann	er stated.		29c. Licens	e number	29	d. Date signed (Month	, Day, Year)
	F 3 F 8			100			NV	59724	/ 7	100 28	2014
	1		30. Name and address of person who com	pleted cause	e of death (Iten	n 23a) (Type,	Print)	,,,,,,,		111000	300/
	0		Menee Perkis	MO	111	W. M	gh St.	Juit J.	14 E1	Kton, MI	2 21921
	Sta		31. Date filed (Month, Day, Year)	32. Re	egistrar's Signa	ture				,	
	Registi	ar	JUL 0 6 2004	men	1	100	arkel	<del>र</del> -			

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			AMEND ITEM #26 PE	State of Maryla R VERB G833 7	nd / Depail 7/02/ <b>@e</b> rt	itment of F	neaith and i Death		ierie <sub>eg. No.</sub> 2 N N	. 21177
	Physici	o.	1. Decedent's Name (First, Middle, Last)		-			2. Date of Deat	h	3. Time of Death
40,2	/Medic	al	IRENE JA  4a Facility Name (If not institution, give:	ANE MORGAN	J		4b. City, Town, or L		4c. County of D	
4	Examin	er	211 EAST SPRUC				DELMAR		WICOM	
	Funeral Director		221-12-4040	7. Age (In yrs	:. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, AUG • 14	Year) 23 D	Birthplace (State or Foreign Country) ELAWARE
	tend		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Loca	ation				10d. Inside City Limits
	e Mery	cto	DELAWARE SUSSEX	K BF	RIDGEVI	LLE				1 ☐ Yes 2X No
	sth with the Meryler 23e or 28e-f show ust be notified	rai Director	10e. Street and Number 4778 FEDERALSE	BURG ROAD		10f. Zip Code 1993			Og. Citizen of What	A
Maryland 21215-0020	72 hours efter deeth with the Merylend natural', or flerne 23a or 28e-f show dical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Movidowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	11	□Yes ŽÕNo			14. Race - Al Black, W Specify: W	
15-0	natu	etec	15. Decedent's Edu (Specify only highest grade	cation e <i>completed)</i>	16a. Decede	ent's Usual Occup ind of work done	oation during most of work d)	king	16b. Kind of Busine	
212	filed within Hygiene. ther than ont, the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		L BUS		T	RANSPOR	TATION
nd		BeC	17. Father's Name (First, Middle, Last)					e (First, Middle, M		
yla	should be and Mental marked o umatic eve	P	ELWOOD H. H					E MAE E		
Mai	47 th 22		19a. Informent's Name/Relationship (Ty KAREN A • RAMEY-		C -777				, City or Town, State OGEVILLE	, DE • 19933
Baltimore,	Peges 1 en nent of Heal nt: If Item 2 iry or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	20h	Place of Disposi	ition (Name of	7	Data	20a Location - City	
Balti	permit. P Depertme Importar any Injur		21. Signature of Juneral Service License	1/6/	WA		ss of Facility ATES FU DELAWA		IOME, INC	•
			23a Part : Enter the disease of complishock, or heart failure. List only or	ications that caused the dea ne cause on each line.						Approximate Interval Between Onset and Death
1	Physician /Medical Examiner		Immediate Ceuse (Find disease or condition resulting in death)	Alrhei	MO MO		nou	l.		Oriset and Death
	nsit	Examiner		). ————————————————————————————————————	,					
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ō	The land	+3	1 Yes 2 No Carlo No C	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur	y at	ome Sesside 28d. Describe ho	w injury occurred	респу) ПТУТКО
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	To the Hospital or A within 24 hours efter To the Funeral Director Completely filled in b	edical		siclan: To the best of my kn ner: On the basis of examin and manner stated.						
	Vithin To the	Me	29b. Signature and title of certifier			29c. Licens	- 1-1	29	ed. Date signed (Mo	nth, Day, Year)
			30. Name and address of person who	mpleted cause of death (Ite	em 23a) (Type. P	rint) 0 6	, ,		177 (	1
P	4		JA Coclean,	ns 1746	11 2	יעייעור	1 44, J	allibu	ruy, n	A 5180A
	Sta Hegistr	200	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	Sporks				

DHMH 16 Rev 6/95

Hegistrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Curtiss Dean Mouk unknown 24 2004 June 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death 13455 Greensburg Road Washington Smithsburg If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug 8, 1943 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 X M 2 □ F 271-40-9468 60 OHIO Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☒ No MD Washington Smithsburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13455 Greensburg RD 21783 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ☐ Yes 2X No Yes, Give Specify: White 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Pastor Church 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nellie L. Garret Stanley B. Mouk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13455 Greensburg RD Sminthsburg, MD 21783 Sheila A. Mouk wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State June 28 Smithsburg, MD Welty Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 21. Signature of Funeral Service Licensee 50 S. Broad ST Waynesboro, PA 17268 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, pr heart failure. List only one cause on eech line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? a. Was an autopsy performed? TLIYES 2010 1\_ Yes 2 No

**Physician** /Medical Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed

Physician/Medical

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Medical Certification: To

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Division of Vital Records, P.O. Box 68760

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel" --- "1--- ery injury or other treumatic events."

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

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25. Was case referred examiner? 26. Place of Death (Check only the) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes/ 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatore

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eddress of person who completed cause of death (Item 23e) (Type, Print)

2-2911 Jefferm BirD Registrar's Signature

State Registrar

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			- Stete Registrar					Cei	tificat	e or L	Jeath			Reg. No	X 11 11	L	211	19
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	Examin		4a. Facility Name (If not inst	tution, give s	treet and nur	nber)			4b. City,	Town, or	Location of	of Death		40	c. County of	Death		
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- To - To - To - To - To - To - To - To	Funeral Director		5. Social Security Number 057-22-7384	6. Sex	M 2□F	7. Age (In		birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di Oct. 26	orth $ay$ , Year $1$	929	Birthpl Count New	ace (State of try) York	or Foreign
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			1 - For State Registrar	State of Maryland / Department	artment of Health and Natificate of Death	dental Hygier	ne	
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}	Exami		4a. Fecility Name (If not institution, give st Lorien Nursing Home	· ·	4b. City, Town, or Location of Death Columbia		4c. County of Deeth Howard	
4.	Funeral Director		5. Social Security Number 6. Sex 084-30-1594	7. Age (In yrs. last birthday)  M 2 F 65 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea Oct. 29,1	9. Birthplace (State or Foreign	
e, Maryland 21215-	1 and 2 sho Health and Im 27 Is m ther traum	To Be Completed by Funeral Director	10a. State 10b. County  MD Howard  10e. Street and Number	10c. City, Town or Lo		10g. (	10d. Inside City Limits  1 ☐ Yes 2 ☐ No  Citizen of What Country?	
			7464 Weatherworn Wa  11. Marital Status  1 Never Married 2 Married  3 Widowed ADDivorced	2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	21046 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Inited States  14. Race - American Indian, Black, White, etc.  Specify:  White	
			15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	Completed) (Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	Kind of Business/Industry	
			17. Father's Name (First, Middle, Last) Nils Harold Pearson  Manager  18. Mother's Name (First, Middle, Maiden Sumame) Anna Unknown					
			19a. Informant's Name/Relationship (Type Susan P. Derrenberg 20a. Method of Disposition	er/Daughter 310	Spring Gate Ct. Nosition (Name of	At Airy, M		
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UNISION OF VITAL RECORDS, P.O. BOX 68 /60, or attanding Physician: The law requires that the death certificate be executed.		by Physician/Medical Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):					
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
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1	led Sta		30. Name and address of person who com	PAN IAJ LIFE TE  32. Refistrar's Signature	Print) RPAL 201-109 BAC	EX RIVER	NECK RA. BALTI-	

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211		30. Name and a	ress of person	who complet	ted caus of	death (Item	The state of the last	Print)	11	Are E	Asten	MD	211	to M		-
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Regist	rar		JUN 0	9 200	The state of	due	K,	Sporte	/							-

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Emily H. Pfautz June 16, 8:05 a M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FutureCare Chesapeake Arnold Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☐ M 2 🛛 F 95 169-26-2153 Yrs. Director 27,1909 Mar. PA Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location or 28e-f show the Medical Examiner must be notified at MD Anne Arundel Arnold 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 College Parkway 21012 USA Itame 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours atter artment of Health and Mental Hygiens. Ordent: If term 27 is marked other than "natural". Or its injury or other traumatte event, the Neulical Example. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Cedar Crest Elementary/Secondary (0-12) Cottege (1-4or 5+) Assistant Dean of Admissions College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry S. Hoffman Ethel Chaney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19975 19a. Informant's Name/Relationship (Type, Print) David H. Pfautz/Son 25001 Lighthouse Road, Unit 113, Selbyville, DE 20b. Place of Disposition (Name of cemetery, crematory or other place) June 21 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Lebanon, PA permit. Page Department of Important: If eny injury or Mt. Lebanon Cemetery 2004 \* 4 Donation 5 Other (Specify) 21. Sometife of Fineral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Ho 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Momes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a Examiner Sequentially list conditions, if any, leaving to introduct cause. Enter Underlying Cause (Disease or injury that initiated events, and the conditions of the Examiner Divisito for as a ponse The law requires that the death certificate be executed use as the burial-transit o Va resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. detached been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate or Attending Physician: director. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 - Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral i 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No 6 ☐ €ould not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L Hospitef Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) (PB. Print) D4955 kvansttighway

State

Registrar

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	/Medio		4a. Facility Name (If no		ive street and nun	nber)		4b. Ci	ty, Town, o	r Location	of Death	June		. County of	<u> </u>	1_14:21	_A_
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	Funeral		5. Social Security Number		Sex 1 □ M 2 2 F		rs. last birthd	Month	der 1 Year is Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D.	ay, Year)		Coun.		Foreign
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	within 72 hours after death with the Maryland ene. than *neturel*, or items 23s or 28s-f show he Medical Evarrinet must be notified at	Funerai Director	11. Marital Status 1 ☐ Never Married	2 Marriad	12. Was Dece Armed Fo 1 ☐ Yes	rces?	n U.S.	3. Was De If Yes, s	cedent of H pecify Cuba	lispanic Ori an, Mexicar	igin? (Spi n, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Black, 1			
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Ž	should nd Me mark matic	Jo	19a. Informant's Name		(Type, Print)		19b. M	ailing Addre	ess (Street			al Route Numb	oer, City o	or Town, Sta	ite, Zip	Code)	
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re,	of Heal	ı	20a. Method of Disposi				b. Place of Di	sposition (f	Name of or other place	ce)	[	Date	20c. L	ocation - Cit	y or To	wn, State	
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Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other traumatic event, The Medical Examinating must be notified at Once.		21. Signature of Funer	ral Service Lic	Roma	Mosli	i	22. Name	and Addre	ss of Facili of G1c	y Joh ouces	nn M. T ster St	aylo . An	r Func napol:	eral is,	Hom <b>e</b> , MD 214	Inc 01
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			30. Name and address														
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene #19a, per/f.home, 6/17/04, Certificate of Death WCHD, E.T Reg. No.? Amended item 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 15, 1925 WALTER F . POWERS June 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner South Point Road Berlin If Under 1 Year Worcester If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1XM 2□ F Yrs. 76 Director Pa. 2 - 7 - 28Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 77 is marked other than "natural", or items 23e or 28e-1 show traumatic event, I'm Medical Exertiner must be rollified at 1 Yes 2 No Director MD Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6554 South Point Road 21811 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1, Xes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Vice President Defense other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Menta! Walter Vander Powers Louise Nolte ဂ္ 19a. Informant's Name/Relationship (Type, Print) Aldine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i Alvine E. Powers/Spouse 6554 South Point Rd. Berlin, Md. 21811 othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Berlin, Md. Sunset Memorial Park 6-21 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ullrich Funeral Home Berlin, Md Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine anding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 1 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Tes 2110 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☑ No ٩ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 PResidence 6 □Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide hours after ā within 24 hours a

To the Funeral C

completely filled Fo the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) no completed cause of death (Item 23a) (Type, Print) 30. Name at

DHMH 17 Rev 1/2001

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

32. Registar's Signature

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			1 - For State Registrar	State of	Marylan	•	artment rtificate			and M	_	giene Reg. No.	1000	21186
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	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
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Ē	Page ent o nt: If ry or		1 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci		SIAIA	stview		-		une	17,2004	New	Castl	e, VA
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7.	requires that the de een signed by the a nould be detached f		Part II. Other significant conditions	contributing to de	ath but not resu	utting in the u	nderlying ca	use give	en in Part I.		23e. Did 1	obacco u	se contribute	to the cause of death?
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5	yalcii is car direct	0	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 12 Ir	npatient 2 🗆	ER/Outpatier	nt 3 D0	A Othe	00		me 5 ☐ Resi		5 □Other (Sp	ecify)
0	ding Physician: n. After this certific funeral director,	n: T	27. Manner of Death	28a. Date o	of Injury h, Day Year)	28b. Time of	1 2	Bc. Injury Work	at k?		28d. Describe	how injur	y occurred	
0	tendin Jeath. tor: Aft the fur	atio	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigation	on	,, ,, ,, ,,	,a.ry	М		Yes 2 1	No				
DIVISION	r Atte er de recto recto	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	286. Place	of Injury - At ho	me, farm, str	eet, factory	, office			28f. Location ( City or To	Street an wn, State	d Number or F )	Rural Route Number,
2	urs aff ral Di	Cer								,			_	
	To the Hospital or Attending Physician: in 24 hours after death as a few death or the Funeral Birector. After this certified completely filled in by the funeral director.	edicai	29a. Certifier  (Check only one)  Certifying P  (Check only one)	and mann	isis of examination stated.	tion and/or in	vestigation,	in my o	pinion, deat	th occurr	ed at the time,	date and	place, and du	e to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier				290	. License	e number			29d. Dat	e signed (Mor	th, Day, Year)
}			> Ptan Jun	~ M.	L.		2	40	370			6/	14/04	
	11		39. Name and address of person who	completed cause	e of death (Item	1 23а) ∏уре,	Print)	7	1 /	,	210	_	-1	MD
	7		YETER WISHE	USKIN	ID, 110	Mosp	tal	1700	d ST	re 3	110, 1R1	ne	trede	uck 20678
	Sta Registr		31. Date filed (Month, Day, JUN 1	7 2004	bylistrays Signa	LUTE K	he	M.						

			1 - For Stete Registrer	State of Ma	ryland .	/ Depa	rtmen tificate	t of H	ealth a Death	ind M	ental Hy	giene Reg. No.			2118	37
	Physici	an	Decedent's Name (First, Middle, La MILLARD)	E.	REYNO	OLDS					2. Date of De Month JUNE 1		, , , , , ,	Year	3. Time of D	
	/Medio Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of	<u>-</u> -	O OIVL		County	of Death	10:40	<i></i>
			30583 Cannon D					isbu					Wico	mico		
	Funeral Director		5. Social Security Number 6. S	Sex 7.Age [X]M 2□F	(In yrs. last	t birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	iy, Year)		9. Birthp	place (State or I	Foreign
	ס		221-10-3704 Usual Residence of Decedent		83		1				May 22	, 19.	21	DeT	aware	
	arylan show	_	10a. State 10b. County		10c. City, T	own or Lo	cation							1	Od. Inside City	
	the M. 28a-f	Directo	Maryland Wicomic	0	Sali	sbur	10f. Zip	Code				10a Citi	zen of M	/hat Cour	1 Tes 2	- X140
	3a or		30583 Cannon Driv					804						mat cour	ill y r	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "netural", or items 23a or 28a-f show eumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Amed Forces? 1 ☐ Yes 2 XN If Yes, Give Year or Dates:				ent of Hi	spanic Orig n, Mexican, Specify:	jin? (Spec , Puerto F	cify Yes or No Rican, etc.)	US.	14. Race	k, White,	ean Indian, etc.	
Maryland 21215-0036	hin 72 ho e. an "netur Medical	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)			6a. Deced (Give life. L	lent's Usua kind of wor DO NOT us	l Occupa k done d e retired,	ition Juring most )	of workin	g	16b. Ki	nd of Bu	siness/Ind	dustry	
2	ted will lygien her th ht, the	Con	8 17. Father's Name (First, Middle, Last			Truck	Driv	er	10 Math	d- N	/FT: A B 81-4-41-			rtat	ion_	
anc	e d is b	To Be	John Edwin	Reynol	ds				Sad:		(First, Middle) Mae			cker	con	
ary	should and Men smarke umatic	F	19a. Informant's Name/Relationship (			19b. Mailin	g Address	(Street a			Route Numb					
Baltimore, M	ss 1 and of Health item 27 r other tr		Patricia Reynold: 20a. Method of Disposition 1又Burial 2 □ Cremation 3 [	S (Wife)	20b. Place	e of Dispo	Canr Sition (Nan natory or or	ne of			lisbury				21804 own, State	
Ē	permit. Pages Department of I importent: if it any injury or o		* 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	(y)	Sprin	ghill	Memory	Card	en Ji	ne 19	2, 2004	Sali	sbu	cy, M	Marylan	d
Ba	permi Depa impo any ii		Muhael	ADec	<b>7</b>	F. 5	ollov 01 Sr	vay I now I	Tunera Hill I	al Ho Road	Salis	bury	iona , Ma	al As ryla		
	Physician /Medical		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin  a.  Due to (or as a	e. CAR	D10 N	YO PA		g, such as o	cardiac or	respiratory a	rrest,			Approximate Interval Betwe Onset and De	en ath
	Examiner	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a		AFIS	)									
8760,	cate be executed oblysicion and the burial-transit	dical Examiner	that initiated events resulting in death) Last	cDue to (or as a	consequen	ice of):										
P.O. Box 68	The law requires that the death certificale be executed tte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of the control	Fetal de	ath 3	Ectopic pro					2	23d. Date Mon	of delive	ry Day Yea	ar
	quires that n signed by uld be deta	δ	Part II. Other significant conditions	contributing to death bu	t not resultir	ng in the ur	nderlying ca	ause give	on in Part I.			obacco u Yes 2[			ne cause of dea	>
Division of Vital Records,		Completed									24a. Was auto perio		d	eath?	psy findings avanted in pletion of cau	ailable ise of
Vita V	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				000		of Death	(Check only	опе)				
on of	ding Pl	tlon; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	/ 28	Outpatien  Time of Injury		Bc. injury Work	4 🗀 1401		ne 5 Aesi 8d. Describe			r <i>(Specif</i> y ed	9	
Divisi	tel or Attences after deather bit Director:	Certification;	3 Suicide 6 Could not be determined	e One Place of lain	ry - At home (Specify)	, farm, stre	eet, factory	, office		2	8f. Location ( City or To	Street and wn, State,	d Numbe )	r or Rura	l Route Numbe	er,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	29a. Certifier 1 ☐ Certifying P. (Check only one) 2 ☐ Medicel Exe	nysicien: To the best o miner: On the basis of and manner sta	examination	dge, death and/or inv	occurred a restigation,	at the tim in my op	e, date and pinion, deat	d place, a h occurre	nd due to the d at the time,	cause(s) date and	and mar place, a	ner as st nd due to	ated. the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of certifier				1	License	70 94				-	(Month, 1	Day, Year)	
).	4,4		30. Name and address of person who				Print)			Sive	er	SAL	5 Bu	eg N	1D 2180	4
	Sta Registi		31. Date filed (Month: Day, Year)	2004 32. R stra	15 r's Signature	4 4	best	,			-					1

			For	State of Maryland / Dep	partment of Health and I	•	
			1 - Stata Ragistrar		ertificate of Death		g. No? 111 21100
П	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year
	/Medio	al		Schmitt	0.00 ***	June	20 2004 7:27 A M
	Examir	er	4a. Facility Name (If not institution, give s 3721 Ligon Road	street and number)	4b. City, Town, or Location of Death Ellicott City	1	4c. County of Death
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda		8. Date of Birth	Howard  9. Birtholace (State or Foreign
	Director			XM 2□ F 74 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Jan 12,	Year) 9. Birthplace (State or Foreign Country) Maryland
	pc ,		Usual Residence of Decedent			1	
	anyla shov	ž	10a. State 10b. County	10c. City, Town or t			10d. Inside City Limits 1 ☐ Yes 2X No
	the M	ecto	MD Howard  10e, Street and Number	Ellicot	tt City 10f. Zip Code	10	
	with Sa or	ā	3721 Ligon Road		21042		lg. Citizen of What Country?
	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "netural", or items 23a or 28a-f show event, the M. died Ex. infact ust be multipled at	Funeral Director		12. Was Decedent Ever in U.S. 13	J. Was Decedent of Hispanic Origin? (S. If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	United States  14. Race - American Indian,
9	or Ite	Fur	1 ☐ Never Married 2 ☐ Married	1 🕱 Yes 2 🗌 No		o Rican, etc.)	Black, White, etc.
8	ours ral',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1947–51	1 ☐ Yes 2 ☐ No Specify:		Specify: White
21215-0036	"nett	Completed	15. Decedent's Edu (Specify only highest grade	e completed) (Giv	edent's Usual Occupation re kind of work done during most of wor	king 1	6b. Kind of Business/Industry
12	withir ene. than	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		City of Auronalia
9	filed Hygid Sther	C	17. Father's Name (First, Middle, Last)	4   PO.	lice Chief  18. Mother's Nam	ne (First, Middle, M	City of Annapolis
an	ld be ental ked c	To Be	John Schmitt		Rose Fel		,
Maryland	should and Men s marke umatic	-	19a. Informant's Name/Relationship (Ty		ling Address (Street and Number or Ru		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28a-1 show entry or other traumatic event, the Medical Examiner in ust be nullised at ance.		Dolores V. Schmitt,	/Wife 3721	l Ligon Road Ellic	ott City,	MD 21042
Baltimore,	of He		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R	emoval from State	position (Name of ematory or other place)	Date 2	Oc. Location - City or Town, State
Ē	Pages tment of I tant: If it		'4 ☐ Donation 5 ☐ Other (Specify)	St. Johr	n's Cemetery 6-23		Cllicott City, MD
Bal	Departr Departr Imports eny inju		21. Signature of Funeral Service License				zke's Family FH Inc.
			23a Part 1 Enter the disease or compli				cott City, MD 21043
			shock, or heart failure. List only or Immediate Cause (Final	cations that caused the death. Do not enter cause on each line.		or respiratory arres	Onset and Death
	Physician /Medical		disease or condition resulting in death)	Metastatic Pancr  Due to (or as a consequence of):	reatic Cancer		5 months
В	Examiner						
Щ	D ==	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequence of):			
	ecute and frans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				
760,	icate be executed physicien and s the burial-transit	cai E	rooding in obain, East	Due to (or as a consequence of):			
687	phys phys s the	edica					
Box (	eath certificat attending phy I for use as the	√Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of delivery
m	death e atte d for	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.O.	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th	Physician/M	9 Unknown	9□ Unknown			
	signed signed d be de	by F	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
Records,	w requir been si should	ted				1 🗌 Yes	2 □ No 3 □ Probably 4 ☑ Unknown
ec	a faw has b e 2 st	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	10					performe 1 Tes 2	
Vital	ding Physicien: The law n. After this certificate has t funeral director, page 2 s	o Be	25. Was case referred to medical examiner?	ospital:	Other	th (Check only one	
ot	Phy rald	$\vdash$	1 ☐ Yes 2 🛣 No 7	28a. Date of Injury 28b. Time 28b.	of 28c. Injury at	ome 5 X Residen 28d. Describe how	ce 6 ☐Other (Specify)
o	Attending F r death. ector: After by the funera	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
Division of	after death after death Director: in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	net and Number or Rural Route Number,
ā	ital or rs afte el Dii	Cer		building, otc. (Specify)		Only or Young	Jidie)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai	(Check only 2 ☐ Medical Examin	sician: To the best of my knowledge, dea ner: On the basis of examination and/or in	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau	se(s) and manner as stated. e and place, and due to the cause(s)
	o the ithin 2 o the	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		d. Date signed (Month, Day, Year)
	F 3 F 8		10/	MD	D41139		June 22, 2004
a	2		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type			Duile 22, 2004
			Maryland Oncology H		55 Little Patuxent	Pkwy, Co	lumbia, MD 21044
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 2 2 200	37 Registrar's Signature	sell .		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Eleanor Edna Schleicher 18, 2004 4:35 June a 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Arnold Anne Arundel FutureCare Chesapeake If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 5, 1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 88 212-09-3273 Yrs MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Arnold Anne Arundel MD 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21012 USA 305 College Parkway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Eleanora Elizabeth Krauss Joseph F. Grandy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 279 Bowline Road, Severna Park, MD Carol Jo Hutzley/Daughter 20b. Place of Disposition (Name of June 22, 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery Baltimore, MD \* 4 □ Donation 5 □ Other (Specify) 2004 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral H 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Par/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death spock, or heart failu Immediate Cause (Final neum disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dualto for as a con de n resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 TYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No

The law requires that the death certificate be executed use as the burial-tran attending physicien and of Vital Records, P.O. Box 68760, been signed by the should be detached has page 2 certificate Attending Physician: director. inis funeral After death.

ō Hospital

the

Physician/Medical Completed by Be Medical Certification; To completely filled in by the Director: after within 24 hours To the Funeral

6 Could not be determined

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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or Items 23a

Director

Funeral

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Completed

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Examiner

other traumatic event, the Medical Exeminer must be notified at

2 should be filed within 72 hours after on and Mental Hygiene.

es 1 and 2 should be fill of Health and Mental Hillem 27 is marked oth

Pages 1 ment of F permit. Pages Department of Important: If it any injury or o

Physician

/Medical

**Examiner** 

Baltimore, Maryland 21215-0036

death with the Maryland

29b. Signature and title of certifier 29c. License number 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 Date filed (Month 32. R

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

281. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

			. For	State of Maryland				_		•	
			For State Registrar		Ce	rtificate c	of Death		Reg. N	6.004	21190
	Physici	an	Decedent's Name (First, Middle, Last)					Mon	_	•	3. Time of Death
	/Media	al	Susan E. S			4h City Tow	n, or Location of [	Geath 6	13	2009 c. County of Death	19:16 M
	Examir	er	Anne Annael Me			Annai		56201		Inne An	adel
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Ye Months Da	ear If Under 24	Hrs. 8. Date Min. (Mon	of Birth	9 Birthr	place (State or Foreign
	Director		216-70-7635	M 2Å F 49	Yrs.	WOTERS	lys Hours	111-	th, Day, Year -21–195		ington, DC
	and and		Usual Residence of Decedent  10a, State 10b, County	10c. City	, Town or Lo	cation			· · · · · · · · · · · · · · · · · · ·	1	0d. Inside City Limits
	Mary I-f eh	tor	Maryland Anne Aru	ındel	F	dgewate	r				1∐Yes 2 <b>XX</b> √o
	th the or 28a e noti	irec	10e. Street and Number	and i		10f. Zip Cod			10g. C	itizen of What Cour	itry?
	23e usit	<b>Funeral Director</b>	161 Riverton Place				1037			USA	
	er dez Items	nne	T. Maria States	12. Was Decedent Ever in U.S Armed Forces?	5. 13.	Was Decedent of If Yes, specify C	of Hispanic Origin Cuban, Mexican, F	n? (Specify Yes Puerto Rican, et	or No-	<ol> <li>Race - Americ Black, White,</li> </ol>	
36	irs aft		1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 <b>∑</b> No If Yes, Give Year or Dates:		1⊡Yes XXX	No Specify:			Specify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ane. than "naturel", or Items 23e or 28e-f ehow the Medical Exament must be inclified at	Completed by	15. Decedent's Educ			dent's Usual Oc	cupation one during most o	f working	16b. F	Kind of Business/In	
2	ithin 7 le. nan "r	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	tired)				
	e filed within at Hygiene. I other than vent, the We	Cor	17. Father's Name (First, Middle, Last)	2 years	Certi	fied De	ntal Ass	sistant Name (First, A		Dental	
and	d be f	o Be		ames Schryer			13. 3.00			nestine N	ichols
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28e-1 show any Injury or other traumatic avent, the Medical Examinar must be routified at any Injury or other traumatic avent, the Medical Examinar must be routified at ance.	P	19a. Informant's Name/Relationship (Typ	_	19b. Mailir	ng Address (Str	eet and Number o			or Town, State, Zip	
	and 2 salth a n 27 is		Thomas L. Vernon/	Companion	161	Rivert	on Pl.,	Edgewat	er, M	21037	
ore	pes 1 and of Health If item 27 or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	20b. Pla emoval from State	ace of Dispo emetery, crer	sition (Name of matory or other	place)	Date	20c. L	ocation - City or To	wn, State
Baltimore,	Pages tment of tant: If it		' 4 ☐ Donation 5 ☐ Other (Specify)	Entombment Lak			-1	18-04		idsonvil.	
Bai	permit. Pages Department of Important: If i eny Injury or one		21. Signature of Funeral Service License	90				_		alas Fune: ewater, M	
			23a. Part1. Enter the disease, or complic	cations that caused the death.						water, Fi	Approximate
	Pnysician		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	1.	10th (	0.06.05				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ	-	ng c	ancer				
	Examiner		Sequentially list conditions, b.								
	ed sit	June	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequ	ence of):						
	be executed ician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):						
760,	ate be executed hysician and the burial-transit	cal	d								
89	0 0 0		IF FEMALE:								
Вох	death certifica e attending ph id for use as th	an/N	23b. Was decedent pregnant 23	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregna	ancy			23d. Date of delive	Day Year
0	that the death certif ed by the attending detached for use as	Physician/Med	in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	4□Pregnant at time of de 9□ Unknown	ath 5	Other (specify	")		- [	Worth	Day Tour
<u>α</u>	The law requires that the tite has been signed by the bage 2 should be detache	/ Ph	Part II. Other significant conditions conf	tributing to death but not resul	Iting in the u	nderlying cause	given in Part I.	23e	Did tobacco	use contribute to th	e cause of death?
Records,	w requires that s been signed b should be deta	ed by							1 ☐ Yes 2	.□No 3 Prob	ably 4 Unknown
000	aw rec is bee 2 shot	Completed						24a.	. Was an	24b. Were auto	psy findings available appletion of cause of
ž		Com							autopsy performed? Yes 2 2	death?	
Vital	ysician: The is certificate director, pag	Be (	25. Was case referred to medical examiner?	V/				Death (Check	only one)		
of	S S	1°	1 ☐ Yes 2 No		ER/Outpatier 28b. Time of	I 3 DOA	and the same of th	-	Residence	6 Other (Specify	')
on	ftel ftel	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Dale of Injury (Month, Day Year)	Injury		njury at Work? I □ Yes 2 □ No		cribe riow inju	ily occurred	
Division	Attending r death. sctor: Alter by the fune	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor	me, farm, str			28f. Loca		nd Number or Rura	I Route Number,
Ö	s afte	Cert	4 - Homicide	building, etc. (Specify)	,			City	or Town, Stat	θ)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Examin	ician: To the best of my know er: On the basis of examinati	vledge, death ion and/or in	occurred at the	e time, date and p ny opinion, death	olace, and due l occurred at the	to the cause(s	and manner as st d place, and due to	ated. the cause(s)
	thin 2 of the omplet	Med	29b. Signature and title of certifier	and manner stated.		29c. Lic	ense number		29d. Da	ate signed (Month,	Day, Year)
)	F ≯ F 8		Much MI	and ma				176		•	
			30. Name and address of person who cor	mpleted cause of death (Item  Ange Ange	23а) (Туре,	Print)	2000	1 10	0	, , , , ,	
			Micah R. Fisher	, Ang Ann	1011	neclico.	1 Cent	er, Ar	mapor	1: mp	
	Sta Registi		31. Date filed (Month Day, Year) 20	32. Engistrar's Signati	B A	house					
	riegisti		_ <del>-</del>	1		-					

			For State Registrar	ricase			nd / Depa		t of H	ealth a	and M	lental Hy		2001.	2119	1
			1. Decedent's Name (	First, Middle, La	st)			-				2. Date of De		Voor	3. Time of Death	h
	Physici /Medio		Justine			Si	ano					June	21,	Day Year 3. Time of Do. 2	5:15 A	М
	Examin		4a. Facility Name (If no			nber)				Location of	of Death					
-			Solomons						well							
I	Funeral Director		5. Social Security Num 066-07-503	95	Sex 1 □ M 21X1 F	7. Age (In yrs. 90	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, De July 8,	ey, Year)	9. Birth Col New		∌ign 
	and		Usuel Residence of Do  10a. State 1	ob. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Lim	nits
	f sho	0	MD	Calvert	. Co.	I	Dunkirk	ζ							1 □ Yes 2X	
	28a	Director	10e. Street and Numb					10f. Zip	Code				10a. Citiz	en of What Co	untry?	
	3a or	0	10100 Vor	lonito (	Stroot			207	754				IT . 9	S. A.	·	
	death ma 2	Funeral	10100 Kay	TOLICE !	12. Was Dece	dent Ever in U	.S. 13.			spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		4. Race - Amer		
9	or Ita	Ē	1 Never Married	2 Married	Armed For	2 NO No					1, Puerto	rican, etc.)				
93	ours iral',	d by	3 ₩idowed 4 (	Divorced	Year or Da	0		1 Yes	2X NO	Specify:				specity: VV[]	Tre	
5	d within 72 hours after death with the Maryland Jiene. I than "natural", or Itama 23a or 28a-f show Itte Medical Ezanda, must be Indilliad at	Completed	15 (Specify	5. Decedent's E only highest gr	ducation ade completed)		(Give	dent's Usua kind of wor	rk done a	tu <i>rina mos</i> i	t of worki	ing	16b. Kin	d of Business/I	ndustry	
12	withir and the state of the sta	dE.	Elementary/Second	ary (0-12)	College (1	-4or 5+)	-	DO NOT us	,				Dooise	to Sah	ool Systo	w
d 2	Hygi Hygi ther int,	ပိ	17. Father's Name (Fit	rst, Middle, Last	+4		Eleme	entary	<u>/_rea</u>			(First, Middle			OOI Syste	111
lan	Q 2 2 2	To Be	Antonio '	Veglia						Cor	neli	a Corin	10			
Maryland 21215-0036	and and is m		19a. Informant's Nam	e/Relationship (			1	-								
€, €	s 1 and 2 if Health Item 27 other tre		Cornelia		dero	20h F										
Baltimore,	of of		20a. Method of Dispos	Cremation 3 €		olale	Place of Dispo				June					
Ħ	permit. Pag Department Important: I any injury o		* 4 □ Donation 5			Geo	orge Wa	asnin 2. Name an	d Addres	MEII.	200 v Lee	4 Funers	Parar	nus. Ne ne Calv	w Jersey ert P.A.	
Ba	permit. Depart Import any inji		Micha	ely. L	ee		83	125 S	outh	ern M	aryl	and Bl	/d., (		MD 20736	
			23a. Part 1. Enter the shock, or heart for Immediate Cause (Fir	ailure. List only	one cause on ea	ach line.	h. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Physician / /Medical	15	disease or condition resulting in death)		a	or as a conseq	mence of):									
	Examiner				b 500 to (	01 43 4 0011369	20100 01).									
	D #	iner	Sequentially list condi if any, leading to immediate. Example Cause (Disease or inju-	tions, ediate	Due to (	or as a conseq	uence of):									
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Las		c. Due to (	or as a conseq	neuce of).									
760,	ite be executed ysician and ne burial-transit	cal E		- (	. d.											
68		ed														
Вох	death certifica e attending ph d for use as th	an/N	IF FEMALE: 23b. Was decedent pr		23c. If yes, outo	come of pregnanth 2 Peta		Ectopic pr	egnancy				23			
	0 0 0	Physician/M	in the past 12 mo 1 ☐ Yes 2 ☑ N 9 ☐ Unknown			ant at time of d		Other (spe						Month	Day Year	
O.4	that the de led by the a detached		Part II. Other significa	int conditions	contributing to de	ath but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did t	obacco use	contribute to	the cause of death?	
Records,	law requires that the as been signed by th 2 should be detache	ted by	·									1 🗆	Yes 2□	No 3⊅ErPro	bably 4 □Unknov	₩П
ecc	e law ri has be je 2 shi	ompleted										24a. Was	osy	prior to co	opsy findings availat	ble of
E	Th ate pag	Con										perfo 1 ☐ Yes	rmed? 2 <b>Z</b> No		2 <b>/2</b> No	
Vital	aician: Th certificate irector, pag	Be	25. Was case referred examiner?		Hospital:			10001	Othe	ar.		(Check only o				
of	Phy r this ral d	. To	1 ☐ Yes 2 No.		1 🗆 1	-	ER/Outpatien		Bc. Injury	4+7 NU					(y)	
on	Attending F r death. sctor: After by the funer	tlon		5 Pending investigatio		nf Injury h, Day Year)	Injury	м	Work	?` /es 2 □ N			now inquity	oodanoa		
Division	after death after death Director: J d in by the f	Certification;		6 Could not b determined	28e. Place	of Injury - At he	ome, farm, str	eet, factory	, office		2	28f. Location (: City or To		Number or Rur	al Route Number,	
	ottal or urs afte ral Dire															
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 19 (Check only 2) one)	Certifying Ph Medical Exar	nysician: To the miner: On the ba and mann	sis of examina	wledge, death tion and/or inv	occurred a vestigation,	in my op	e, date and inion, deat	d place, a th occurre	and due to the ed at the time,	cause(s) a date and p	nd manner as s lace, and due t	stated. o the cause(s)	
	To the I within 2. To the I complet	ž	29b. Signature and titl	e of certifier	1.				License				29d. Date	signed (Month,	Dey, Year)	
•			· /	James &	land	e Mr	7		7476	, / @			Ju	ne 21,	2004	
	5		30. Name and address	2-177					1 a	Da	O - 3	am	14	1 am 1 00	COO	
	Sta	te	David J.  31. Date filed (Month,	Tardlo, Day, Year)	₩.D. 32. Re	14090 egistr s Signa	ooTowo	ns is	Tand	ra.,	201	onons,	wary.	land 20	080	
	Registr	_		JUN 2	3 2004	Bloom	a K	goo	B							

		State of Maryland / Dep	partment of Health and Mental Hygi	iene
				og. No. 1114 21192
	ician		2. Date of Death Month JUNE	Day Year 16 2004 6:20 P M
	dical niner		4b. City, Town, or Location of Death	4c. County of Death
		FAHRNEY-KEEDY NURSING HOME	BOONSBORO	WASHINGTON
Funer		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. NOV. 19	9. Birthplace (State or Foreign Country)
Directo	or	216-14-5990 1 M 2124F 82 Yrs.  Usual Residence of Decedent	NOV. 19	, 1921 MARYLAND
nylano show		10a. State 10b. County 10c. City, Town or t	_ocation	10d. Inside City Limits
h the Maryland r 28a-f show	Directo	MARYLAND WASHINGTON	HAGERSTOWN	1 ☑ Yes 2 ☐ No
death with the Maryland ms 23a or 28a-f show frives to notified at	2	10e. Street and Number 14 PARK AVENUE	10f. Zip Code 10 21740	og. Citizen of What Country? U.S.A.
U30 burs after death with ral', or Items 23a or Examirer rust be	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian,
OU36 hours after tural, or Ite	F		1 ☐ Yes 2 ☑ No Specify:	Black, White, etc.
	od be	3 ☑ Widowed 4 ☐ Divorced Year or Dates:		16b. Kind of Business/Industry
within 72 ene. Than "na!	plet	(Specify only highest grade completed)  (Size Elementary/Secondary (0-12)  (Size Elementary/Secondary (0-12)	ee kind of work done during most of working  DO NOT use retired)	I OD. KING OF BUSINESS/INCUSTRY
N 2 2 2 2	Completed	8	HOMEMAKER	OWN HOME
De fil	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, M	
aryia should and Men marke umatic	ဥ		ANNA MAY STOTTLEN ling Address (Street and Number or Rural Route Number.	
and 2 st and 2 st satth and n 27 is n			26 NATIONAL PIKE, CLEAR SPI	
D - 1 5 5		20a, Method of Disposition 20b. Place of Disp		20c. Location - City or Town, State
ILIMOF it, Pages rtment of I rtant: If it		'4 □Donation 5 □Other (Specify) BOONSBOI		BOONSBORO, MARYLAND
Dall permit. Departr Imports any inju	Suce	21. Signature of Furbrai Service Liverty e Paul M. Dean 1		d National Pike
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		ro, Maryland 21713
Physicia	n		E HEART FAILURE	Onset and Death
/Medica	al	disease or condition resulting in death)  a.   Due to (or as a consequence of):	E REALI / AILONE	. 10 4
Examine		Sequentially list conditions, b.		
rted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
ate be executed hysician and he burial-transit		Due to (or as a consequence of):		
ate be ex hysician the buria	Icai			
Certifica certifica ding ph	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		
death cer death cer e attendir ad for use	cian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery  Month Day Year
t the c	hys	1 U Yes 2 MNo 9 Unknown		
COIGS, F.O. BOX 08  wrequires that the death certifica been signed by the attending ph should be detached for use as th	by P	Part II. Other significant conditions contributing to death but not resulting in the		acco use contribute to the cause of death?
w requires been signs should be	eted			s 2 No 3 Probably 4 Unknown
The law ate has b	Completed		24a. Was an autopsy perform	prior to completion of cause of
VICAL ilcian: Tl certificate rector, pa	ပိ	25. Was case referred to medical	1 ☐ Yes 2 26. Place of Death (Check only one	No 1 Yes 2 No
Physici This cerral direc	ToB		Othor	
ing Pl	ino ino		Work?	w injury occurred
VISION Attending ar death. ector: Afte	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si	M 1 Yes 2 No	eet and Number or Rural Route Number,
al or A	Certification:	4 Homicide determined building, etc. (Specify)	City or Town,	State)
DIVISION OF VITAL MEDIAN TO THE INCOME TO THE PROPERTY OF THE	edical (		th occurred at the time, date and place, and due to the car nvestigation, in my opinion, death occurred at the time, date	use(s) and manner as stated.
thin 24 the F the F mplete	Medi	one) and manner stated.  29b. Signature and title of certifier		d. Date signed (Month, Day, Year)
		Mel	D 52327	1/10/01
11-10		30. Name and address of person who completed cause of death (Item 23a) (Type		5/01
2H-10		Khalid M. Waseem, M.D. 1126 Opal (	Court, Hagerstown, Maryland	1 21742
Regi:	State strar	31. Date filed (Month, Man Year) 8 2004 32. Registrar's Signature	Joerle	

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

cm	1		1 - For State Registrar		epartment of Health and No	/lental Hyg	giene					
	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Las Richard Gail     As. Facility Name (If not institution, give Washington Count	Stanley, Jr.	4b. City, Town, or Location of Death	2. Date of Dea Month June	23 2004 9:33  4c. County of Death	ath)				
	Funeral Director	4.		The specific properties of the second	Months Days Hours Min	8. Date of Birth	Washington  9. Birthplace (State or Fo	reign				
	the Maryland r 28a-f ahow rollfled at	rector	10a. State 10b. County WV Jeffer  10e. Street and Number	son Char	r Location Les Town 10f. Zip Code		10d. Inside City Li 1 ☐ Yes 2 2					
36	be filed within 72 hours after death with the Maryland stal Hygliene. ad other than "natural", or Itams 23c or 28e-f ahow event, the Medical Exertimetri ust be recitified at	by Funeral Director	Cattail Run Rd  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced		25414  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		US					
Maryland 21215-0036	~ *	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 11th	ucation 16a. D to completed) (C College (1-4or 5+)	ecedent's Usual Occupation Sive kind of work done during most of work le. DO NOT use retired)  DE Layer		16b. Kind of Business/Industry Richard R.B.Stir Construction	1e				
Maryland	2 shoutd and Mer is marks aumatic	To Be	17. Father's Name (First, Middle, Last) Richard Gail S 19a. Informant's Name/Relationship (7 Loma M. Stanle	ype, Print) 19b. N	18. Mother's Nam  Loma Ma  lailing Address (Street and Number or Rur  4 Hickory Cove F	ae Will	iams r, City or Town, State, Zip Code) 3787	73				
Baltimore, I	parmit. Pages 1 and 1 Department of Health Important; If itam 27 any injury or othar tr 2000.		20a. Method of Disposition 1 □ Burial 2XX remation 3 □ '4 □ Donation 5 □ Other (Specify	Removal from State 20b. Place of D Still Lt.	isposition (Name of company of other place)  torium  6/28	Date 3/2004	20c. Location - City or Town, State Smithsburg, Md					
7.	w		21. Signature of Funeral Service Licent August 1992  23a. Part 1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final	lications that caused the death. Do not	PO Box 838, Char enter the mode of dying, such as cardiac	Funeral Home Les Town, WV 25/11/ Proper Approximate Interval Between						
E	death certificate be executed  Reading physician and to use as the burial transit	Ical Examiner	disease or condition resulting in death)  Sequentially list conditions, tay, washing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a		ase						
O. Box 68	death certific e attending p id for use as	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year					
ords, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions or	ntributing to death but not resulting in th	e underlying cause given in Part I.		pacco use contribute to the cause of death					
<u>۳</u>	The ate h page	e Completed	25. Was case referred to medical		36 Blace of Death		y prior to completion of cause death? 2 ☐ No 1 Ses 2 ☐ No	able of				
of	ing Phya After this uneral dii	To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 ER/Outpa 28a. Date of Injury (Month, Day Year) 28b. Tim Inju	e of 28c. Injury at	me 5 Reside	ence 6 Other (Specify) ow injury occurred					
5	To the Hospital or Attand within 24 hours after death To tha Funeral Diractor; completely filled in by the f	al Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	eath occurred at the time, date and place	City or Town	suisa(s) and manner as stated					
)	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certifier	iner: On the basis of examination and/or and manner stated.	r investigation, in my opinion, death occurr  29c. License number  O.C.M.E.	ed at the time, da	ate and place, and due to the cause(s)  9d. Date signed (Month, Day, Year)  June 24, 2004					
	Sta Registr		30. Name and address of person who comes in the comes in	32. Registrar's Signature	111 Penn Street, E	Baltimor	e, Maryland 21201					

	1	•	For State Ragistrar		aryland / De	partment ertificate					Reg. No. 🤈 [	04	21191
	Physicia		1. Decedent's Name (First, Middle, La GLADYS ESTHER		RICKER					JUNE 26		Year	3:45 PM
	/Medic Examin	er	4a. Facility Name (If not institution, given 302 BUENA VISTA D			, ,		Location of		J		ty of Death	
*	Funeral Director		212 12 2797		e (In yrs. last birthd 89 Yrs	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Month, Da JULY 3	T, Year) 914	9. Birth	place (State or Foreign otry) YLAND
	land ow	1	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	Location							10d. Inside City Limits
	death with the Maryland ims 23a or 28a-f show rither to invitited at	ctor	MARYLAND CARROL	L	WEST	IINSTER							1 XXes 2 □ No
	with th	Director	10e. Street and Number			10f. Zip					10g. Citizen o		
	eath v	erai	302 BUENA VISTA D	12. Was Decedent	Ever in U.S.		1157 lent of Hi		igin? (Sp	pecify Yes or No Rican, etc.)	UNITED 14. Ra	ice - Amer	ican Indian,
920	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental hygiene if the firm 27 is marked other then "natural", or items 23a or 28a-f show tiem 27 is marked other then "natural", or items 25a or 28a-f show other traumatic event, the Medical Evaluation must be indiffed at	by Funeral	1 Never Married 2 Married  **Widowed 4 Divorced	Armed Forces?  1  Yes 2	No	If Yes, spec		n, Mexicar Specify:		Rican, etc.)	Spec	ack, White ify: WH	, etc. ITE
2-0	72 hou	eted	15. Decedent's E (Specify only highest gr		(0	ecedent's Usua live kind of wo	rk done o	luring mos	it of worl	king	16b. Kind of	Business/l	ndustry
121	within 8ne. then *	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	e. DO NOT us HOMEMA		)			DO	MESTI	C
Maryland 21215-0036	be filed tal Hygid d other event, il	Be Co	17. Father's Name (First, Middle, Las							e (First, Middle		ame)	
ylar	ould b	10	PHILIP EDWARD KIN		10h N	la ilina Addraga	/Stroot			NN SIMM		n State 7	in Codel
Mar	nd 2 sh lth and 27 Is m		19a. Informant's Name/Relationship MILTON E. TAYLOR/							SVILLE,		1228	p 0000)
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any njury or other ODE:		20a. Method of Disposition  XX Burial 2 □ Cremation 3 0  4 □ Donation 5 □ Other (Spec		20b. Place of D cemetery, MORELAN	crematory or o	ther plac	PARK	κ 6/:	Date 29/04	20c. Location		own, State  MARYLAND
Baltin	permit. I Departm Importar any injur		21. Signatuse of Funeral Service Lice		Linker	MYERS-	DORB LLTS	ÖRÁW STRE	FUN	ERAL HOI WESTM	ME, P.A	• MD 2	1157
,			23a. Part1. Enter the disease, or cor shock, or heart failure. List on	nplications that cause one cause on each	the death. Do not	enter the mod	le of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
7 %	Pnysician		Immediate Cause (Final disease or condition resulting in death)	- Pul	mena	ay fi	1	Sis					years
	/Medical Examiner		1930ting in doutin		a consequence of)	4							0
	P ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of)	L							
1	sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequence of)							-	
760	w ~ w	caiE		d								_	
. 68	entifica ling ph e as th	Med	IF FEMALE:	222 16							00.1.5		
.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pa 5 ☐ Other (sp						ate of deli Jonth	very Day Year
<u>α</u>	res that I		Part II. Dther significant conditions	contributing to death t	out not resulting in the	ne underlying o	ause giv	en in Part I	l.	_			the cause of death?
ord	w require been sig should b	ted	HAN: EN A	NDEWIGE	ton			-			Yes 2 No		obably 4 Unknown
of Vital Records,	The law and are has be page 2 sh	Completed by	- Calibe	Or How				<u></u>		24a. Was auto perf 1 \( \text{Yes}		prior to death?	topsy findings available ompletion of cause of
/ita	sician: The certificate har rector, page	Be	25. Was case referred to medical examiner?	Hospital:			Oth	05		th (Check only			
of	Physical threat of the physical direction of	. To	1 Yes 2 Ne	28a. Date of Inj	ent 2 ☐ ER/Outp ury 28b. Tin		28c. Injur Wor	4 🗆 N	ursing H	ome 5 Res 28d. Describe	idence 6 C how injury occ		ify)
ion	ittending I death. ctor: After y the funer	ation	1 Natural 5 Pending 2 Accident investigati	(Month, Da	ay Year) Inji	M M		k? Yes 2□	]No				
Division	al or Atte s after dea il Directo id in by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place of Ir	jury - At home, farm tc. (Specify)	i, street, factor	y, office				(Street and Nur wn, State)	mber or Ru	ral Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 1 Cartifying I	Physician: To the best aminer: On the basis and manner s	of examination and/	death occurred or investigation	at the tir i, in my o	ne, date ai pinion, de:	nd place ath occu	, and due to the rred at the time	, date and place	e, and due	to the cause(s)
	Totl Totl comp	Ž	29b. Signature and little of certifier	m. Hen	uen mo	29		los	-		CJ28		n, Day, Year)
	6		30. Name and address of person wh		death (Item 23a) (T				ייי אר	1 5000	DMTNICHT	D 1//II	21157
	* C+	ate	CHARLES M. HENSO  31. Date filed (Month, Day, Year)		532 BAL/	IMORE	תאחמ	, 511	<u>. 20</u>	I, WES.	IMINSTE	K, ML	41137
1/2	Regist		JUL 0 6 20	04 3	va B	Spi	reks	, •					
		2004		/	,								

			State of Maryland / D  1- For State AMEND ITEM #21 PER FH G8337/6	epartment of Health and M Derthicate of Death		ene
	Dhysisi		Decedent's Name (First, Middle, Last)		2. Date of Death Month	
	Physicia /Medic		Charlotte Stempel		Junel	2004 2124 M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under/24 Hrs.	8. Date of Birth (Month, Day,	
	Director		215-16-8993 1☐ M 2☑ F 82 Y	rs. Months Days Hours Min.	June 21,	1921 Maryland
	within 72 hours after death with the Maryland ene. Itan "naturel", or llems 23e or 28a-f show tte Madical Examater i ital Le i adiffed at		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	8a-fs	Funeral Directo		onsburg		1 ☐ Yes 2 No
	with the	Ö	10e. Street and Number	10f. Zip Code		g. Citizen of What Country?
	leath	eral	7158 Walston Switch Road  11. Marital Status 12. Was Decedent Ever in U.S.	21849		nited States  14. Race - American Indian,
ယ	or Item	Fu	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White, etc.
21215-0036	ours a	d by	3 ☐Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Caucasian
<u>2</u>	"natu	etec	15. Decedent's Education 16a. [ (Specify only highest grade completed) (	Decedent's Usual Occupation  Give kind of work done during most of workir  life. DO NOT use retired)	חר	6b. Kind of Business/Industry
2	withir ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ecretary	.   '	Maryland State Police
	illed Hygir other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	
<u>Ja</u>	should be and Mental s marked o umatic eve	ToB	Harry Clifton Butler	Dorath	nea Jaco	bs
Maryland	C1 00 - 85	Į.		Mailing Address (Street and Number or Rura		21049
	1 and Health Bm 27 ther tr		Ronald L. Stempel Son 715  20a. Method of Disposition 20b. Place of I	58 Walston Switch Roa		Onsburg Maryland Oc. Location - City or Town, State
no	ages int of l t: If it		1 ☐ Burial 2 【Cremation 3 ☐ Removal from State cemetery	crematory or other place)		
altimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee PER DVR	ol Crematory  6/3/20		over, Delaware
m	permi Depa Impo any ir once	- 4	RUDOLPH P. MOORE	Moore Funeral Home, 12 South Second Stre	P.A. Pet Dent	ton Maryland 21620
			23a. Fart1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause in each line.	t enter the mode of dying, such as cardiac or	r respiratory arres	st, Approximate Interval Between
3	Prysician	- 27	Immediate Cause (Final disease or condition	churtin Pal	moren	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of	11 2 10	7	
		E.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	hear ally		georg.
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	8"		1
oʻ	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of	):		
8760,	ate he he	dical	d		·	
9 ×	eath certific attending pl	0	IFFEMALE: 23b Was deceded program: 23c. If yes, outcome of pregnancy			
Вох	atten	clan	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
P.O.	that the de ed by the detached	Physician/M	1   Yes 2   No 9   Unknown			
S, T	res tha igned I be det	by P	Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
ord	w require been si should I				1 🗆 Yes	2 No 3 Probably 4 Unknown
ec	e law a has by	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Vital Records,						No 1 ☐ Yes 2 ☐ No
<u>=</u>	Attending Physiclen: r death. ector: After this certific by the funeral director.	o Be	25. Was case referrer to medical examiner?  1	26. Place of Death Other: 4 Death		ce 6 ☐ Other (Specify)
o	ding Phys h. After this funeral dii	<b>-</b>	27. Manner of Death 28a. Date of Injury 28b. Tir	ne of 28c. Injury at 2.	8d. Describe how	
Š	tendin Jeath. tor: Af the fur	atlc	2 Accident investigation	M 1 Yes 2 No		
Division of	after death Director: In by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	1, street, factory, office 2	8f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
_	Hospitel 24 hours a Funerel ( stely (illed		29a. Certifier 1 ertifying Physician: To the best of my knowledge,	death occurred at the time, date and place, a	nd due to the cau	se(s) and manner as stated
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	(Check only 2 Medical Examiner: On the basis of examination and one) and mariner stated.	or investigation, in my opinion, death occurre	ed at the time, date	e and place, and due to the cause(s)
	To the within 2 To the complet	Ř	29b. Signature and title of certifier	29c. License number	290	i. Date signed (Month, Day, Year)
			Motor	DZJXS	9	1404
			30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)	1 - 1	
	Sta	te	31. Date filed (Month, Day, Year) 32@Registrar's Signature	ITHWay Utive, Da	1,5 bur	717021804
	Registr		JUN - 3 2004 Bosen &	Jthway Drive Sa		

Charlotte Stempel 215-16-8993

		1 _ State	State of Maryland /	Department of H Certificate of I			2001.	21196
		Registrar  1. Decedent's Name (First, Middle, Last)		Octimente of t		Reg. No Date of Death	<b>5</b> G O	3. Time of Death
Physic			ABETH	TAYLOR		Month Da	ay Year 4 2004	10:14 P <sup>M</sup>
/Med Exami		4a. Facility Name (If not institution, give st			Location of Death		c. County of Death	10.14 1
	37	160 CHERRY BLOSSO	M FARM LANE	CHURCH	HILL	Qτ	JEEN ANNE'	S
Funera		Social Security Number     6. Sex	7. Age (In yrs. last	Months Days	Hours Min. (/	Date of Birth Month, Day, Year	9. Birthpla Count	ace (State or Foreign
Director		213-62-2903	85	Yrs.		R. 18, 191	L9 MARYL	
and		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location			10	ld. Inside City Limits
Mary!	20	MD QUEEN AN	NE C	IIDCII IITTI				1 ☐ Yes 2 No
the 1	Director	10e. Street and Number	NE 5 CH	URCH HILL  10f. Zip Code		10g. C	itizen of What Count	ry?
death with the Maryland ms 23a or 28e-f show fmust be notilised at	ā	160 CHERRY BLOSSO	M FARM LANE	21623	1		USA	
death	Funeral		2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	ispanic Origin? (Specify '	Yes or No-	14. Race - America	
ING 21215-0036  be filed within 72 hours after death with the Marylan ital Hygiene.  d other than "naturel", or Itams 23a or 28e-f show event, the Medical Examinar must be notified at		1 Never Married 2 Married	1 Tes 2 No	1 ☐ Yes 2 X No	Specify:	11, 610.)	Black, White, e	ITE
27275-0036 d within 72 hours af giene. er than "naturel", or the Medical Exem	d by	3 X Widowed 4 Divorced	Year or Dates:					
15-1 1721	Completed	15. Decedent's Educa (Specify only highest grade		<ol> <li>Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired</li> </ol>	during most of working	16b. I	Kind of Business/Indo	ustry
d 27275- filed within 72 Hygiene. Wher then "nel	d Hic	Elementary/Secondary (0-12)	College (1-4or 5+) -0-	SECRETARY	,	МА	NUFACTURI	NG CO.
Hyging The		17. Father's Name (First, Middle, Last)	-	DECKLIAKI	18. Mother's Name (First			10 00.
Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic event	To Be	JOHN J. M. SKINNE	R		SUSAN E	THEL BEN	SON	
arylar should be and Menta is marked	-	19a. Informant's Name/Relationship (Typ	e, Print) 1	9b. Mailing Address (Street a	and Number or Aural Aou	ute Number, City	or Town, State, Zip (	Code)
- 650 -		JOSEPH G. TAYLOR,	JR./ SON 1	60 CHERRY BLO	SSOM FARM L	ANE, CHU	JRCH HILL,	MD 21623
of He rothe	1 "	20a. Method of Disposition	como	e of Disposition (Name of etery, crematory or other place	Date	20c. l	Location - City or Tow	vn, State
attimore, mit. Peges 1 er partment of Hea portant: If item y injury or othere.		1 ⚠ Burial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	moval from State CHURO	CH HILL CEMET	ERY 6-18-20	04	CHURCH HI	LL, MD
Baltimo permit. Peg Department Important: It		21. Signature of Funeral Service Licenses	1.10.	22. Name and Addres		MENTAL IS	IDIED AT HO	ME D A
n ೩೭೯೪	1 8	Momas K. St.	elfenlin	408 S. LIB	LFENBEIN & I ERTY ST., C	ENTREVIL	LE, MD 21	617 P.A.
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. E cause on each line.	Do not enter the mode of dyin	g, such as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
Physician	_	Immediate Cause (Final disease or condition	cerebril	Jasenla	accide	nt	3	3 days
/Medical Examiner		resulting in death)	Due to (or as a consequent					1
Examine,		Sequentially list conditions, b.	Due to (or as a consequence					4
led Isit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to for as a consequent	Ca OI).				
8760, sate be executed shysicien and the burial-transit	xan	that initiated events c. resulting in death) Last	Due to (or as a consequence	ce of);		<u>-</u>		
8760 ate be e thysicien	dicalE							
687 rtificate ng physi as the	edic	0.			V-10-7-7	= 1		
death certific death certific e attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy 1□Live birth 2 □Fetal dea				23d. Date of deliver	y
death death e atte	lcia	in the past 12 months?	4 Pregnant at time of death				Month E	Day Year
of the ache	hys	9 Unknown	9□ Unknown					
Cords, F w requires tha been signed is should be det	by F	Part II. Other significant conditions cont	ributing to death but not resultin	ig in the underlying cause give	en in Part I.		use contribute to the	
ould	ted					1 Tes 2	No 3 Proba	bly 4 Unknown
Hecc le law r has be ge 2 sh	ple				-1	24a. Was an autopsy	prior to com	sy findings available pletion of cause of
	Completed				1	performed? 1 ☐ Yes 2 ☑ N	death?	
Vision of Vital Records, Attending Physicien: The law requires the death. ector: Atter this certificate has been signe by the funeral director, page 2 should be continued.	Be	25. Was case referred to medical examiner?			26. Place of Death (Ch	eck only one)		
Of Phys this al di	J.	1 195 2 200		Outpatient 3 DOA	4 I Nursing Home		6 ☐Other (Specify)	
Ing F ling F After funer	lon	Manner of Death t Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28I	b. Time of 28c. Injury Work	/at 280.1 k? Yes 2 ∐No	Describe how inju	try occurred	
Division of to Attending Physafter death. Director: After this lin by the funeral dil	icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Injury - At home			ocation (Street a	and Number or Rural	Route Number
Div for A after Direction by	Certification;	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, tam, siresi, ladicity, office	1 6	City or Town, Stat	(e)	
Division ( To the Hospitel or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral		29a. Certifier Certifying Physi	cian: To the best of my knowled	dge, death occurred at the tim	ne, date and place, and d	lue to the cause(s	s) and manner as sta	ited,
ne Ho 1 24 h ne Fu iletely	edical	(Check only 2 Medical Examinone)	er: On the basis of examination and manner stated.	and/or investigation, in my or	pinion, death occurred at	the time, date an	id place, and due to t	the cause(s)
To the comp	ž	29b. Signature and title of certifier	7.	29c. License	e number	29d. Da	ate signed (Month, D	ay, Year)
		100	len am	m= 0/6	788		6/15/	04
2 V Y	1	30. ame and address of person who con	poleted cause of death (Item 23	la) (Type, Print)	01.	-)	711	N alla
711		wayne 2.	1 Janan	un, Mi	), Chl.	5H-1	040	1421620
S' Regis	trar	31. Date filed (Month, Day, Year)	32. Registrar's Signature				ď	`
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			For State	State of Ivia		rtificate of			g. Ng? () () [s	21107
	4 %		Registrar  1. Decedent's Name (First, Middle, Last)			Timouto or	Dodin	2. Date of Death		3. Time of Death
	Physici /Medic		Melvin	Earle	Thoma			June	15 2004	1 7:27 a <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give s		rring		or Location of Death		4c. County of De	
	Funeral		Somerford Place As 5. Social Security Number 6. Sex		EVING e (In yrs. last birthday)	Annapo	If Under 24 Hrs.	8. Date of Birth	Anne Ar	irthplace (State or Foreign Country)
	Director			M 2□F	83 Yrs.	Months Days	Hours Min.	Nov 19,	1920 Vi	rginia
	d within 72 hours after death with the Maryland jene. Ir than "natural", or Items 23e or 28e-f show the Mydical Ereich at must be indiffed at	ž	10a. State 10b. County		10c. City, Town or Lo		D	1_		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the A	Director	MD Calvert  10e. Street and Number			10f. Zip Code	Frederic		g. Citizen of What (	
	3a or		220 Double Oak Roa	d North		20678			USA	
	ms 2	Funeral	· · · · · · · · · · · · · · · · · · ·	12. Was Decedent I Armed Forces?	Ever in U.S. 13.		Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - An	nerican Indian,
9	or Ita		1 ☐ Never Married 2 X Married	1 X Yes 2 1 If Yes, Give	10	1 ⊡ Yes 25√2 No	Specify:	Hican, etc.)	Black, Wh	nite, etc.
00	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	941-46				W	hite
15	n 72	lete	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ting 1	6b. Kind of Busines	s/Industry
21215-0036	f within piene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		& radar t	echn.	Federal	Government
þ	e filed Il Hygi other	BeC	17. Father's Name (First, Middle, Last)					e (First, Middle, M	laiden Sumame)	
/lar	should be nd Mental rmarked c	ToE	Nathaniel Herber	t Thoma	as		Wanda			Radar
Maryland	W =		19a. Informant's Name/Relationship (Ty)			,			City or Town, State,	
	is 1 and 2 of Health a ttem 27 is other train		Dona Rae Thomas, s	pouse	P.O.	And the Control of the Control of the Control	, Prince		Oc. Location - City of	678
altimore,	Pages nent of H int: If Ite		1 XBurial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cre	matory or other pla	сө)			
플	F 65 3		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	90		2. Name and Addre	tery 06-18	0-2004	<i>funtingto</i>	עוו, ווא
Ba	permit. Departi Import. any inj		Milovian R	Gran			neral Hom	e, P.A.,	Owings,	MD 20736
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused	the death. Do not en				st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Don	ion tia					Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):					
. 10	Examiner		Sequentially list conditions, if any, leading to immediate	)						
	ed isit	ulne	cause. Enter Underlying Cause (Disease or injury	Due to (or as	a cons Auence of):					
. 5	e be executed sician and e burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):					
260	e be e	ā								
68	tificat ng phy as the	ledi							Ta-same	
Вох	death certificate e attending physical for use as the b	an/N	23b. was decedent pregnant	3c. If yes, outcome 1□Live birth		Ectopic pregnanc	v		23d. Date of d	
	0 0 2	Physiclan/Medlo	in the past 13 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of death 5	Other (specify)	·		Month	Day Year
P.0	that the		Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	nderlying cause giv	ven in Part I	23a Did toba	acco use contribute	to the cause of death?
Vital Records,	Se Pa	d by	Ceselvo V	uscula		celevel		1 🗌 Yes	¥	Probably 4 Unknown
20	w require s been si	lete	General	Deli	Petr			24a. Was an	24b. Were	autopsy findings available
Re	The lay	Completed						autopsy perform	prior to ed? death? No 1 ☐ Ye	completion of cause of
ital		BeC	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one		2 2 2 2 1 2
of V	Physicien: this certific ral director,	ပု	1 □ Yes 2X No	lospital: 1 🔲 Inpatie			4 LI Nursing Ho	ome 5 🗆 Resider	nce Other (Sp	ecity ASSISTED
n c	fe fe	0	27. Manner of Death  Natural 5 Pending	28a. Date of Injur (Month, Day	ry 28b. Time o lnjury	Wo		28d. Describe how	w injury occurred	Living
Division	eat or:	icat	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of Init	ury - At home, farm, st		Yes 2 □No	28f Location (Str.	eet and Number or I	Rural Route Number,
ΟŃ	after Direction by	Certification:	4 Homicide determined	building, etc	c. (Specify)	con ractory, omco		City or Town,		ratal ricato riambor,
	To the Hospitel or Attendii within 24 hours after death. To the Funerel Director; A completely filled in by the fu	Medical C	29a. Certifier (Check only one) Certifying Physical Exemination	sicien: To the best of the basis of and manner sta	of my knowledge, deat examination and/or in	h occurred at the til vestigation, in my o	me, date and place, opinion, death occur	and due to the car red at the time, da	use(s) and manner ate and place, and du	as stated. ue to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed Mor	nth, Day, Year)
)			YAX			D'	5 102	5	6/16/0	4
			30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type,	Print)	2-2	21.14	ANTUN	1400000000
p.	10+1		UNUTATIVELY IT	VE STE	Sales and the sales are a sales and the sales are a sa	STACUS	IND. O	11041K	אוועה	MOKKI MIN
9.	Sta Registr		31. Date filed (Month, Day, Year)	7 2004 A	s Signature	Source				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 18, 2004 6:30 Ам **Physician** Templeman Mary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles Hughesville 16724 Prince Frederick Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. B. Date of Birth
July 2, 1948 9. Birthplace (State or Foreign 6 Sax 7. Age (In vrs. last birthday) 5. Social Security Number 1 □ M 2 X F 213-06-6789 55 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 XYes 2 □ No Hughesville Directo Maryland Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20637 16724 Prince Frederick Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian,

1 ☐ Yes XXNo

Library Technician

Toye

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

hen

Due to (or as a consequence of)

Due to (or as a consequence of)

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

9☐ Unknown

4☐Pregnant at time of death

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Marys Ch Cem

3 Ectopic pregnancy

3 DOA

28c. Injury at Work?

5 Other (specify)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Facility

Specify:

Eva

18. Mother's Name (First, Middle, Maiden Sumame)

I.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town Mary Land 16724 Prince Frederick Rd Hughesville,

6/24/04

MO1323 Adams Funeral Home P.A. Aquasco, Maryland

Ansulin

death with the Maryland 28a-f show traumatic event, the Medical Examiner must be notified at or items 23a or Maryland 21215-0036 "natural", 72 e filed within 7 at Hygiene. Pages 1 and 2 should be fill timent of Health and Mental H tant; if Item 27 is marked off jury or other traumatic even Baltimore. permit. Page Department of Important: if any injury or once.

**Funeral** 

Director

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Completed

Be

**Physician** /Medical Examiner

Examiner Physician/Medical Completed by Be

use as the burial-tran physician been signed be should be detailed page 2 Medical Certification: To After thi thours after death.

Funeral Director: Af ely filled in by the ful

The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records, or Attending Physician: within 24 hours a To the Funeral I

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 1 Nes 2 No 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 4 - Homicide

29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier youhio

1 Never Married Married

15. Decedent's Education (Specify only highest grade completed)

Wendell Templeman/Husband

1101

N Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

College (1-4or 5+)

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

21. Signature of Funeral Service Licensee

12

20a. Method of Disposition

Odessa

DeSales

Jagour:

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient

28a. Date of Injury (Month, Day Year)

29c. License number

Doo 50883

1 Yes 2 No

6/18/2004

Yania M. Tagourt 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,MP 20646 WINESa 11655

State Registrar

31. Date filed (Month, Day, Year)

5 Pending

investigation

6 Could not be determined

32. Resistrar's Signature

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

DHMH 17 Rev 1/2001

**ORIGINAL** 

Approximate Interval Between Onset and Death

2063

23d. Date of delivery Month Day

Black, White, etc.

Specify: Black

Federal Government

Mitchell

16b. Kind of Business/Industry

Bryantown,

Maryland

Year

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

26. Place of Death (Check only one)

24a. Was an autopsy performed? 1 Yes 2€ No

Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specity)} \)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Amended Items 28a-28f per Medical Examiner, 06/08/2004, Carroll County, wjl Amend Item 28f per Dr. 1632, 06/24/04dhb State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2004 **Physician** MARY MILDRED TRUMPOWER 5, 7:25 A M JUNE /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WESTMINSTER CARROLL CARROLL HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months 1 ☐ M 2 🔀 F 78 Director 1926 MARYLAND 214-26-0160 Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow the Medical Examiner must be notified at WESTMINSTER 1 No 2 No MD. CARROLL Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 255 EAST MAIN ST. USA deeth by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☑ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DIETARY ASSISTANT STATE permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygle, important: If item 27 is marked other th eny injury or other traumatic event, II a 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LUCKETT MOSNER LILLIAN **JASON** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) STARBOARD DR., TANEYTOWN, MD. 21787 BRIAN N. TRUMPOWER SON 21 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State MEADOW BRANCH CEM. 6/9/04 WESTMINSTER, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 Approximate Interval Between Onset and Death 23a. Pert1. Extend disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** tar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed for use as the burial-transit e lo. Due to ler as a consequence of): W IN ROVED BY MEDICAL EXAMINER P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy CERT in the past 12 months? Month Year Day 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 3 Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 Yes 2 No To the Hospitei or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☑ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Division 1 Natural 5 Pending investigation death. 2 Accident 05/31/2004 1 ☐ Yes 2 No Intraoperatively Unknown after death Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State), 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 T Homicide 200 Memorial Avey, Westminster, MD Carroll Hospital Center within 24 hours a To the Funerel C completely filled 1 Destifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Description Physicien: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 00051924 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WIL who completed cause of death (Item 23a) (Type, Print) East Main St Westwinster Hoskin MA ed 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Spelle Registrar

Tippett, DeboRA Jean Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year 55 **Physician** О м lune. 2004 <u>Debora Jean Tippett</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington County Hospital Washington County If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 2 F 47 Yrs. Director 20 1956 District Columb 219-72-3066 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f ahow other traumatic avant, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director West Virginia Berkeley Falling Waters 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Items 23a Williamsport Pike 25419 U.S.A. 9387 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Doctor's Office 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be n and Mental t 2 Jean B. Dodd John W. McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25419 item 27 i Francis Sonny Tippett (Husband) 9387 Williamsport Pike Falling Waters, W. Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of the Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory June 14 04 Smithsburg Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Fuenral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) for use as the burial-transit The law requires that the death certificate be executed liobla that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, pe 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes funeral director, page 2 should Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 🗌 Yes 2/ or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manger of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the

5H-12 State

2

29b. Signature and title of certifier

Registrar

Mymber

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

negan 32. Pagistrar's Signature 29d. Date signed (Month, Day, Year

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Ī9 Iris E. Via June 2004 10:30A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3212 Parliament Place West Friendship Howard If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Jan 19, Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛛 F Director 230 03 1414 85 Yrs. **1919** Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If itam 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at Funeral Director 1 ☐ Yes 2 XNo MD Howard West Friendship 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3212 Parliament Place 21794 United States permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "naturar", or Items 23 any injury or other traumatic event, the Madical Examinar must any injury or other traumatic event, the Madical Examinar must pines. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 20 No þ Specify: 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John D. F. Aker Leslie F. Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patsy V. Boyd/Daughter 3212 Parliament Place W. Friendship, MD 21794 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Thornsprings Cem. 6-25-2004 Pulaski, VA 21. Signature of Funeral Service Licensee M01044 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HUTEVIOSELEX /Medical Que to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transit and Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. attending physicien for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death signed by the at d be detached to 5 Other (specify) ☐ Yes 2X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2**X** No 1 ☐ Yes or Attending Physician: after death. Diractor: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death Check onl. one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐XNo P 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 36246 June 21, 2004 (y) ad 30, home and address of person who completed cause of death (Item 23a) (Type, Print) coverbrook Rd Columbia MD 21044 Olwine MD 31. Date filed (Month, Day, Year)
JUN 2 2 gistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

nysician	1. Decedent's Name (First, Middle, Last)	Wal	per		2. Dete of Dear Month	Day	Year 0.55
dical niner	4a Facility Name (If not institution, give street and	i number)		4b. City, Town, or L		4c. County	
ral	Lorien Cehab  5. Social Security Number  6. Sex	_	i. last birthday) If Under 1	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, NOV 11		9. Birthplace (State or Fore. Country)
or	Usual Residence of Decedent	<sup>f</sup>   55	Yrs.		Nov 11	, 1948	Maryland
_	10a. State 10b. County		ity, Town or Locetion				10d. Inside City Limit
ecto	MD Howard  10e. Street and Number		Ellicott Cit		1	0g. Citizen of V	
	801 Roundhill Road			1043		-	d States
by Funeral Director	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married	Decedent Ever in to decedent Ever in to decedent Ever in to decede the following to the decedent Ever in to decede the decedent Ever in the Ever in the decedent Ever in the decedent Ever i	If Yes, specif	nt of Hispanic Origin? (S <sub>I</sub> y Cuban, Mexican, Puerto ▼ No Specify:	pecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc. White
201	15. Decedent's Education (Specify only highest grade comple		16e. Decedent's Usual	Occupation	king	16b. Kind of Bu	
Completed		ge (1-4or 5+)		done during most of work retired)	9	Cond on	_
Ş	17. Father's Name (First, Middle, Last)	2	Salesman	18. Mother's Nan	ne (First, Middle, I	Copier: Maiden Surnam	
To Be	George William Walper			Helen Te	eresa Rol	œrts	
_	19a. Informant's Name/Relationship (Type, Print)			Street and Number or Ru	ral Route Number	r, City or Town,	
	Mary F. Best/Friend	001		nill Road El			D 21043 City or Town, State
	20a. Method of Disposition  1XI Burial 2 □ Cremation 3 □ Removal fi 4 □ Donation 5 □ Other (Specify)		Place of Disposition (Name cometery, crematory or oth leadowridge C	emetery 6-2	22-2004	Elkrid	ge, MD
	23a. Part1. Enter the disease, or compfications the shock, or heart failure. List only one cause	M01044	4112  O	d Columbia I	Pike Elli	icott C:	Family FH Indity, MD 21043
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Esquentially fist conditions, if any leading to immediate		(or as a consequence of):	caner			4 mon
<b>dedical</b>	Sequentially fist conditions, if any, leading to immediate cause. Enter Undertying Ceuse (Disease or injury that initiated events resulting in death) Last  d	Due to (	or as a consequence of):				
Physician/	Part II. Other significant conditions contributing	o death but not re	sulting in the underlying car	se given in Part I.	23b. Did to	bacco use con	tributa to tha csusa of deat
	To bacco al	suse	bu hist	oru	120	es 2 No	3 Probably 4 Unkno
Completed by					24a. Was a perform		24b. Were autopsy findings available prior to completion of cause of death?
EO					1 U Y	9 2 No	1 ☐ Yes 2 ☐ No
Be	25. Was case referred to medical examiner?  Hospital:				th (Check only on		
ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	☐ Inpatient 2 ☐ ate of Injury Month, Dey Year)		Nursing H Dinjury et Work? 1 ☐ Yes 2 ☐ No	ome 5 ☐ Reside 28d. Describe ho		
Certification:	3 Suicide 6 Could not be determined 28e. P	lace of fnjury - At I uilding, etc. (Spec	nome, farm, street, factory, ify)	office	28f. Location (St City or Town		er or Rural Route Number,
edicai	29a. Certifier (Check only one)  Certifying Physicien: To the control of the control of the control on the control of the cont						
×	29b. Signature and title of certifier	$\sim$ ,	m.D. 29c.	icense number <b>5653</b> [	2	9d. Date signed Tun-	ind due to the cause(s)  (Month, Day, Year)  21, 28.4  MD 21044
ì	30. Name and address of person who completed than Li, 10700	cause of death (Ite	m 23a) (Type, Print) y Ridge	read,	Columb	oik,	mD 21044
State egistrar	31. Date filed (Month, Day, Year)  JUN 2 2 2004	2. egistrar's Sign	H Snews				

DHMH 16 Rev 6/95

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Deeth 1 Decedent's Name (First Middle Last) Day Month Tivne 04 4b. City, Town, or Location of Death 4c. County of Deeth Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Sept. 7 19 Months Days Hours 1□M 2X)F Yrs. 1949 54 Maryland 10b. County 10c. City, Town or Location

**Physician** Carol Elizabeth WILKES 0012 /Medical 4a Fecility Neme (If not institution, give street end number) Examiner 10805 Clinton Avenue 5. Social Security Number Birthplece (Stete or Foreign Country) **Funeral** Director 220-54-4277 Usual Residence of Decedent with the Merylend 10a. State 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Washington Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 Funeral 10805 Clinton Avenue U.S.A. permit. Pages 1 end 2 should be filed within 72 hours efter death Depertment of Health end Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√☐ No Specify: White Specify: \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public School 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Jane E. Paden Joseph L. Renner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gregory A. Wilkes - Husband Hagerstown, Maryland 21740 10805 Clinton Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 6/21/04 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home E. Wilson Blvd. Hagerstown, Maryland 21740 Pert 1. Enter the disease, of complial tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical coed MOS Examiner Due to (or es a consequence of) Examiner physician and s the buriel-trensit or Attending Physician: The lew requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical Due to (or as a consequence of) for use es the Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown þ is certificate has been signi director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 X No 1 ☐ Yes 2 ☐ No 1 - Ye 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 Yes 2□ No 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 🗆 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ≥H-10 ceuse of deeth (Item 23a) (Type, Print) NerTrez A 31. Date filed (Month, Day, Year) 8 2004

DHMH 16 Ray 6/95

Registrar

Physici	an.	1. Decedent's Name (First, Middle, Las Pear1	) E11a	Wheeler	,		2. Date of Dea	Day Y	3. Time of Death
/Media	al	4a. Facility Name (If not institution, give		MILEGIEI		or Location of De	<u>May</u>	25, 20 4c. County of	04 10:10A <sup>M</sup>
Examir	er	Calvert County	Nursing	Center	Pri	nce Fre	ederick	C	alvert
Funeral Director		5. Social Security Number 220-16-8803 6. Security Number 10	x 7. Ag □M 2∑0 F	e (In yrs. last birthda 86 Yrs.	y) If Under 1 Year Months Days			, 1918	. Birthplace (State or Foreign Country) Maryland
M. T		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
Fed Sh	tor	Maryland Calv	ert	I	luntingt	own			1 ☐ Yes 2X No
or 28g	Jirec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	
s 23a	rall	3715 Solomon	S Island		Was Deceded of	20639	(Specify Ves or No		S A American Indian,
Department of Peatin and Mental Typiens. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items and item and items and items are applied at an once.	by Funeral Directo	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 N  If Yes, Give  Year or Dates:	No	If Yes, specify Cu		(Specify Yes or No erto Rican, etc.)	Black,	White, etc. Black
hatur	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dec (Gi	cedent's Usual Occu ve kind of work done DO NDT use retir	ipation during most of v	vorking	16b. Kind of Busin	ness/Industry e Else's
h and Mental Hyglene. 7 is marked other than "I traumatic event, the Mac	Idm	Elementary/Secondary (0-12)	College (1-4or	5+) life	Domest.			Home	e rise s
other ent, III	To Be Completed by	17. Father's Name (First, Middle, Last)			Domesic	18. Mother's N	ame (First, Middle,	Maiden Sumame)	
arked atic ev	To B	Kelop	В	luck		Ting		Haro	
127 is mer traum		19a. Informant's Name/Relationship (7 George Buck/So		3715	Solomo	ns Isla	Rural Route Number and Rd.	er, City or Town, Sta Hunting	town, MD20639
nt: If iten iry or oth		20a. Method of Disposition 1		20b. Place of Dis cemetery, c Easters	position (Name of rematory or other pl 1 UMC Ce	асе) m. 5/:	Date 28/2004	Lusby	
Departr Importa any inju once.		21. Signature of Funeral Service Licen	evell					uneral rince F	Home red.,MD20678
ysician Medical taminer	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause Fits Undanying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  Due to (or as	ne.	enal	Jailu		Test,	Approximate Interval Batween Onset and Death
physician and s the burial-transit	dical E		d	Demen.	h'a				
attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2□ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	B□Ectopic pregnan 5 □ Other (specify)	су		23d. Date of Month	of delivery Day Year
y the atteriched for u		Part II. Other significant conditions of	ontributing to death b	out not resulting in the	underlying cause g	iven in Part I.			ute to the cause of death?
gned by the be detached	Ď								
s been signed by the should be detached	Ď						24a. Was autop perfo	an 24b. Websy priormed? dea	re autopsy findings available r to completion of cause of th? Yes 2 No
ificate has been signed by the or, page 2 should be detached	Completed by	25. Was case referred to medical				-1	24a. Was	2 No 1	re autopsy findings available r to completion of cause of th? Yes 2 No
vlier this certificate has been signed by the uneral director, page 2 should be detached	To Be Completed by	25. Was case referred to medical examinar? 1   Yes a   No 27. Manner of Death	28a. Date of Inju (Month, Da	ent 2 □ ER/Outpat ury ury Year) 28b. Time lnjur	of 28c. inj	ther: 4 Virgursing ury at ork?	24a. Was autop perio 1   Yes Death (Check only of Home 5   Resid	2 No 1	Yes 2 No
vlier this certificate has been signed by the uneral director, page 2 should be detached	To Be Completed by	25. Was case referred to medical examiner? 1 ☐ Yes a ☑ No 27. Manner of Death	28a. Date of Inju (Month, Da		of 28c. Inj W 1	ther: 4 Vivursing ury at ork? ☐ Yes 2 ☐ No	24a. Was autor performent of the performance of the	ane)  dence 6 □Other ( now injury occurred	Yes 21 No
vlier this certificate has been signed by the uneral director, page 2 should be detached	Certification; To Be Completed by	25. Was case referred to medical examinar?  1   Yes   a   No    27. Manner of Death   Natural   5   Pending investigation   3   Suicide   6   Could not be determined    29a. Certifier   Certifying Ph (Check only 2   Medical Exem	28a. Date of Inju 28a. Place of Inju 28e. Place of Injui 28e. Plac	ary Year)  28b. Time Injur  28c. (Specify)  of my knowledge, de of examination and/or	of 28c. Inj. W 1[street, factory, office	ther: 4 Vix ursing ury at ork?  Yes 2 No	24a. Was autor performed to the control of the cont	a No 1 □  dence 6 □ Other ( now injury occurred  Street and Number ( vn, State)	Yes 2 Le/No (Specify)  or Rural Route Number,  er as stated.
vlier this certificate has been signed by the uneral director, page 2 should be detached	To Be Completed by	25. Was case referred to medical examiner? 1	28a. Date of Inju (Month, Da	ary Year)  28b. Time Injur  28c. (Specify)  of my knowledge, de of examination and/or	of M 15 28c. Ini W 15 28c. Street, factory, office at the investigation, in my	ther: 4 Vix ursing ury at ork?  Yes 2 No	24a. Was autor period 1 Yes  Peath (Check only of Home 5 Resident 28d. Describe to 28d. Describe to 28d. Location (3 City or Townson, and due to the courred at the time,	a No 1 □  dence 6 □ Other ( now injury occurred  Street and Number ( vn, State)	Yes 21 Pro (Specify)  or Rural Route Number,  er as stated. I due to the cause(s)
fler this certificate has been signed by the neral director, page 2 should be detached	edical Certification; To Be Completed by	25. Was case referred to medical examiner?  1 Yes a No  27. Manner of Death Natural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier Check only one)  29b. Signature and title of certifier	28a. Date of Inju 28a. Date of Inju (Month, Da  28e. Place of In building, e'  ysicien: To the best and manner st	ary Year)  28b. Time Injur  28c. (Specify)  of my knowledge, de of examination and/or	of 28c. Inj. M 1[ street, factory, office ath occurred at the investigation, in my 29c. Licen	ther: 4 V ursing ury at ork?  Yes 2 No  time, date and pla opinion, death or opinion	24a. Was autor performed at the time,	dence 6 Other (now injury occurred street and Number ovn, State)  cause(s) and manndate and place, and 29d. Date signed (No. 2)	Yes 2 VerNo (Specify)  or Rural Route Number,  er as stated. If due to the cause(s)  Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 7:45 P<sup>M</sup> JUNE 9 2004 JOSEPH WILLIAM ZWOBOT /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner OUEENSTOWN QUEEN ANNE'S 212 OLD POINT LANE If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Hours 1**X** M 2□F 22, 1920 **NEW JERSEY** 83 Director 072-14-7601 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No **OUEENSTOWN** QUEEN ANNE'S Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21658 212 OLD POINT LANE Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married WHITE 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupetion 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) CONSTRUCTION 12 4 CONSTRUCTION ENGINEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) mit. Pages 1 and 2 should be flit partment of Health and Mental Hy portant: If Item 27 Is marked oth y injury or other traumatic event Be MARGARET POPP JOSEPH ZWOBOT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 212 OLD POINT LANE, QUEENSTOWN, MD MAYBEL RUTH ZWOBOT/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. CHESAPEAKE CREMATORY | 06/11/2004 STEVENSVILLE, MD 4 Donation 5 Other (Specify) 21. Sign wire of Fundral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 0 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition pulmonary Chronic obstructive Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of). Examiner lany leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) the attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown hed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by should be 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 Yes 2 □ 1 ☐ Yes 2 \( \text{No} \) Attending Physician: director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 2 No 1 🗌 Yes Medical Certification: To this completely filled in by the funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 TYes investigation within 24 hours after death. To the Funerel Director: A 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)
130 Luve Point Rd. # 107 Stevenn: // stevensville #107 31. Date filed (Month, Day, Year) 32. Regisfar's Signature State Registrar 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Katherine Buehling Zirkle June 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Hagerstown Washina Washington County Hospital
Social Security Number 6. Sex 7. Age (In yrs. last birthday) ton 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 🔀 Days Hours 76 Yrs. 284-26-0115 March 1,1928 Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40 Wayside Ave. Apt. 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No 3 ☐ Widowed 4 X Divorced Spacify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Technolotist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Buehling Ruth Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2055 N. Vermont St. #204 Arlington, Va. 22<u>007-2373</u> Cynthia Anne Zirkle (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State smithsburg Crematory June 13, 04 Smithsburg, Maryland • 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Golays disease or condition resulting in death) Due to (or is a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

Directo

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Be

**Funeral** 

Director

itam 27 ia marked othar than "natural", or items 23a or 28a-1 show other traumatic evant, Ite Madical Examinar : ust be notified at

2 should be filed within 72 hours after and Mental Hygiene. is merked othar than "natural", or Itel

permit. Pages 1 and 2 st Department of Health and Important: If itam 27 ia n any injury or other traun

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

the Maryland

Examiner burial-transit attending physician Physician/Medical as the t þ Completed To the Hospital or Attanding Phyaician: within 24 hours after death. To the Funaral Diractor: After this certified Be P Certification: Medicai

IF FEMALE

23b. Was decedent pregnant in the past 12 months?

25. Was case referred to medical examiner?

1 🗌 Yes

27. Manner of Death

Matural

2 Accident 3 Suicide

4 | Homicide

29a. Certifier

2 No

23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death

4☐Pregnant at time of death

3 DEctopic pregnancy 5 Other (specify)

Month Dav 23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed?

1 TYes

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes

	2	6. Place of Death (Ci	neck only one)	
DOA	Other:	4 Nursing Home	5 Residence	6 ☐Other (Specify)

Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

↑ Impatient 2 ER/Outpatient 3

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

 Location (Street and Number or Rural Route Number, City or Town, State) the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Man Ell

JUN 17 2004

5 Pending investigation

6 Could not be

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed ause of death (Item 23a) (Type, Print) Mary & Money

Hospital:

354 nil). Wil

State Registrar

DHMH 17 Rev 1/2001

PH-D'

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year :55 PM JEROME H. ZELLER, SR. June 2004 de /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Franklin Baltimore guare 1405 If Under 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
Maryland **Funeral** Days XXM 2□F Months Hours 1920 83 Yrs Director Nov. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Baltimore County Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USA 1 Judywood Lane Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 □ Never Married 20 X Married NOXYes 2 No Specify White If Yes, Give Year or Dates: WW 1 Yes 20XNo Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Printer 11 yrs, 17. Father's Name (First, Middle, Last) Printing Industry 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ Mark J. Zeller Mary E. Comes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit Pages 1 and 2 Department of Health a Importent: If item 27 is any in ury or othar trau once. Louise A. Zeller (Wife) 1 Judywood Lane Baltimore, Md. 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Garrison Forest VA Cem. 7~1~04 Baltimore. Md. \*4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 21. Signature of Funeral Service Ligensee Kassek 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) a Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death Check onl one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 🗙 No 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 TYes 2 TNo 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical | Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 certificate this After Director: A in by the f within 24 hours at To the Funerel D completely filled it To the within 2

28a-f show

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"neturel",

and Mental Hygiene.

Baltimore, Maryland 21215-0036

State Registrar

30. Name and address of person who completed calle of death (Item 23a) (Type, Print) tranhlin Ur. Michael

29b. Signature and title of certifier

32. Registrar's Signature

Drive, Baltimore, Mp. 21337

29c. License number

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Lest) 2. Date of Death June 24, <sup>Day</sup> 2004 Physician 1:00pm George Louis Zier /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Frederick Frederick Homewood @ Crumland Farms If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Apr 2.6, 1915 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F 577**-**16**-**2748 89 Yrs. Illinois Director Usual Residence of Decedent death with the Maryland 10a. Stete 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified. Frederick Frederick Maryland 1 ☐ Yes 2XXXVo Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7407 William Road 21702 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1X) Yes 2 □ No 1942 If Yes, Give Yeer or Detes: 1946 Black, White, etc. 1 Never Married Married altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White δ, 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrator Gov't- State Dept 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Η Zier Mary McMahon ္ရ 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9572 Woodland Road, Woodsboro, Maryland 21798 Stephen M. Zier/Son 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg Crematory Jun 26, 2004 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Ligensee 22. Name end Address of Facility Keeney & Basford P.A. Funeral Home 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, Approximate Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting In deeth) Last Due to (or es a consequence of): ettanding physician and inough to physicians as George Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? 24e. Was an autopsy performed? Completed 1 □ Yes 2 to No 1 TYAS 2 No. of Vital Be 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death Medical Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending investigation death. 1 ☐ Yes 2 ☐ No i Director: A 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ò To the Hospital o within 24 hours at To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steled. 2 Medicel Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature eng title of certifier 29c. License number

Toll House

32. Registrar's Signature

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

Registrar

State

SAJJAD

31. Date filed (Month, Day, Yeer)

JUL 0 6 2004

			r lease	State of Maryland / Depa	artment of Health and	•	•	
			1 - For State Registrar	-	rtificate of Death	Reg. N	0001	21209
	Physici	an	1. Decedent's Name (First, Middle, Las	( )	1	2. Date of Death Month	Qay Year	3. Time of Death
	/Media	al	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deat	JULY 15	4c. County of Deat	f 3:10 M
	Examir	ier	HARBOR HOSPITE		BALTIMORE CI	1	NIX	0
	Funeral		5. Social Security Number 6. Se	ex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs	8. Date of Birth	9. Birt	hplace (State or Foreign
	Director		Usual Residence of Decedent	Yrs.	Months Days Hours Min.	7-1-0	24	WD.
	ryland how		10a. State 10b. County	10c, City, Town or Lo	ocation			10d. Inside City Limits
	8a-fs	Funeral Director	mD. Home !	trundel PASA	idena			1 □ Yes 2 No
	with the	Dire	10e. Street and Number	1	10f. Zip Code	10g. 0	Citizen of What Co	ountry?
	death ms 23	nera	3824 Wist	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Ame	
36	or Ita	y Fu	Never Married 2 Married	1 ☐ Yes 250 No If Yes, Give	1 Yes 2 No Specify:	to ricall, etc.)	Black, White	oh 1.
Ö	within 72 hours after death with the Maryland ane. Than 'natural', or Itams 23a or 28a-f show a Medical Examiner must be mailfied at	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	dent's Usual Occupation	16b.	Kind of Business/	Industry
21215-0036	thin 72 en "na Medit	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) (Give	kind of work done during most of wo DO NOT use retired)	rking		1
S	filed with Hygiene ither thai		Intant	Intant	Intant	(5: 44: 44: 44: 44: 44: 44: 44: 44: 44:	エハトの	<u> </u>
Maryland	wuld be fi Mental H arked otl	o Be	17. Father's Name (First, Middle, Last)	DIB. KI	$\mathcal{M}$	me (First, Middle, Maid	∍n Sumame) K	. 11
ary	2 should and Men Is marke sumatic	To	19a. Informant's Name/Relationship (7	Type, Print) 19b. Mailir	ng Address (Street and Number or Ri	ural Route Number, et	or Town, State, 2	Zip Code)
	nit. Pages I and 2 should be filed within 72 hours after death with the Marylan attrinent of Health and Marual Hygiene attrinent of Health and Marual Hygiene attrinent. If I fam 23a or 28a-f show ortant: If I fam 21s marked other than "natural", or I fams 23a or 28a-f show injury or other traumatic event, I'm Marilical Examiner must be mailified at injury or other traumatic event, I'm Marilical Examiner must be mailified at 8a.		Christopher Buckl		Westwood Manor			
Baltimore,	Pages 1 nent of H int: If Iten iny or oth		20a. Method of Disposition 1 Burial 2 XCremation 3	Hemoval from State		y 05	Location - City or	
İtir	permit. Page Department of Important: If any injury or once.		*4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen	110010 010	ematory Inc.   2  Name and Address of Facility		timore,	Maryland Home, P.A.
B	permit. Departr Imports any inji		+ Lie 2. 2	sting of.	3111 Mountain Roa			
			23a. Part 1. Enter the disease, or companies shock, or heart failure. List only	plications that caused the death. Do not ent one cause of each line.	er the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		BEMATURITY			Onset and Death
	Examiner			Due to (or as a consequence of):				
	о <i>:</i> ::	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c		<u> </u>		
760,	ate be executed nysicien and he burial-transit	icai E	l	d				
	rtificati ng phy as the		IS SERVALE.	V				
Вох	death certificat e attending phy od for use as th	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of del Month	ivery Day Year
P.O.	0 0 0	Physician/Med	1 Yes 2 No 9 Unknown	4 Pregnant at time of death 5 □ 9 Unknown	Other (specify)			
S, D	The law requires that the ate has been signed by the page 2 should be detached.	by Pł	Part II. Other significant conditions of	ontributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco		the cause of death?
ord	w require been signature					1 🗆 Yes	2 <b>X</b> √o 3 □ Pr	obably 4 Unknown
Record	has b	Completed				24a. Was an autopsy performed?	prior to d	topsy findings available completion of cause of
		e Co	25. Was case referred to medical		26 Place of De	1 ☐ Yes 2 💢		2 No
<u> </u>	dis ys	To B	examiner?	Hospital: 1 Inpatient 2 ER/Outpatien	Othor	Home 5 Residence	6 ☐Other (Spe	city)
	ding Ph h. After th funeral		27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	Work?	28d. Describe how in	jury occurred	
Division	ttan deat deat tor: / the	licati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	28f. Location (Street	and Number or Ru	ıral Route Number.
<u>&gt;</u>	alor A s after il Dire	Certification:	4  Homicide	building, etc. (Specify)	50, 100toly, 51100	City or Town, Sta		
	To the Hospital or A within 24 hours after To the Funaral Directompletely filled in by		(Check only 2 Medical Exam	ysician: To the best of my knowledge, death niner: On the basis of examination and/or inv	n occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the cause arred at the time, date a	(s) and manner as	stated. to the cause(s)
	o the lithin 2.	Medicai	one)  29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Montl	
)	β∓ĕ		2 hala	1	D45354		Y 151- 2	
	1			completed cause of death (Item 23a) (Type,	Print)			
			ADITYA PARSHAD  31. Date filed (Month, Day, Year)	MD. PA .; 3001 SOUTH	HANOVER STREET, 1	BANTIMORE,	MARYLAN	D 21225
	Sta Registr		31. Date filed (Month, Day, Year)	Woz. negistrar s oignature				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year CHESTER ARTHUR BOWEN 4, 11:00 PM JULY /Medical 2004 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1813 CLEARWOOD ROAD PARKVILLE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1**X** M 2 ☐ F Days Director 213-22-0219 80 3/16/1924 MARYLAND Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or Items 23e or 28e-f show other traumatic event, the Medical Eracinar raise he rotified at 10d. Inside City Limits MD BALTIMORE PARKVILLE 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1813 CLEARWOOD ROAD 21234 USA death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1X☐Yes 2☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married þ 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7/ h and Mental Hygiene 7 Is marked other than "n BALTIMORE COUNTY Elementary/Secondary (0-12) College (1-4or 5+) 8TH GRADE ROADS ROAD CREW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOSEPH BOWEN MARY WEIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum once. ELLA BOWEN WIFE 1813 CLEARWOOD ROAD BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MORELAND MEM. PARK \* 4 ☐ Donation 5 ☐ Other (Specify) 7/9/2004 Hillendale, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STROKE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the burial Box 68760 Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. 1 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate Division of Vital 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After the Hospitel or Attending Natural 2 Accident 5 Pending hours after death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 | Homicide within 24 hours a the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 032543 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STHOMBENO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

			Amend Item #41	state of	Marylag	633 <sup>D</sup> 996 Cei	Tificate of	Health and Death	Mental Hy	rgiene Reg. No⊋ ()	101	21211
	Physicia		1. Decedent's Name (First, Middle, Las		1				2. Date of De	eeth Dey	Year	3. Time of Death
	/Medica	al	Henry 4a Fecility Neme (If not institution, give		aviste			Pocksi <sup>m</sup> h	July relacation of Deat		TOO 4	4:10 P
	' Examine	≛r	716 Walters Mill		,			Dorlda	, MD		Harfo:	rd
	Funeral Director		220-24-60/1	ex 02 M 2□ F	7. Age (In yrs. 92	last birthday) Yrs.	If Under 1 Yea Months Days		n. (Month, Di	rth ay, Year) 1-12	9. Birthp Coun Eng	lece (State or Foreign try) Land
	72 hours eftar death with the Maryland natural; or items 23a or 28a-f show dical Examiner must be notified at	ctor	Usuel Residence of Decedent  10a. State  10b. County  Ba	ltimore	Din	y, Town or Lo					11	0d. Inside City Limits
	with the por 28	Funeral Director	10e. Street end Number Broen	no Re	1		10f. Zip Code	3		10g. Citizen of		•
	me 23	Jera	11. Maritet Stetus	12. Was Dece	dent Ever in U	,S. 13. V	Z (ZZ	Hispanic Origin? ( ben, Mexican, Pue	Specify Yes or No		d Stat	
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours eftar death with the Marylar Depertment of Heelth end Mentel Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other traumatic event, it a Madical Examiner must be notified at once.	by Fur	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Ford 1 ☐ Yes If Yes, Give Year or Da	2 XNo		Yes, specify Cu ☐ Yes 2 XNo		rto Rican, etc.)	Spec	ack, White, o	White
15-0	n 72 ho	eted	15. Decedent's Ed (Specify only highest gra	ucation de com <i>pleted)</i>		16e. Deced	ent's Usuel Occu	pation during most of weed)	orking	16b. Kind of I	Business/Ind	lustry
212	should be filed within and Mentel Hygiene. a marked other than " umatic event, tra Men	Completed by	Elementary/Secondary (0-12) 12 Years	College (1-	4or 5+)		o <i>nor use retir</i> ainter	9d)		Steel	Indus	strv
	el Hyg other	Be -	17. Fether's Neme (First, Middle, Last)					18. Mother's Na	ame (First, Middle			
Maryland	should to	0	William Bavister			T			rice Stol			
Ma	and 2 sho selth end n 27 is m		19a. Informant's Name/Reletionship (7 Barbara Bradford/		r			Forest				Code)
Baltimore,	permit. Pages 1 and Depertmant of Heelth Important: If Item 27 any Injury or other tr once.		20a. Method of Disposition		С	lace of Disposemetery, crem	sition (Name of atory or other pla	ace)	Date	20c. Location	- City or To	
ţim	tmant tmant tant: If		1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☒ Other (Specify	Entombm		el Air	Mem, Gd	ns. 7/7/				aryland
Bal	permit. Pages 'Depertment of H Important: If the any Injury or of		21. Signature of Funeral Service Licen:	E/E	De S	<b>V</b>	Name and Addr da - Ruck 922 Wise	ess of Facility Funeral a Ave. I	Home of undalk,		-	222
	er Tari in in		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that can me cause on ea	used the death ch line.							Approximate Intervat Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition	is	chernic	cari	liomy	pathy			1 1	Onset and Death
,			resulting in death)		Due to (o	r as a consequ	vence of):	1			1	
	cuted	Examiner	Sequentially list conditions	bCOV	Due to (o	has a consequ		sease				
90,	cate be executed physician and the bunal-transit	EX.	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	C			,				ļ	
68760,	ficate I	200	that initiated events resulting in death) Last		Due to (or	as e consequ	ence of):					
Box	leath certifica attending plant of for use est	Z		d								
	at the death certi	310	Part II. Other significant conditions co	ntributing to dea	th but not resu	ulting in the un	derlying cause gi	ven in Part I.	23b. Did	tobacco use co	ontribute to	the cause of death?
s, P.O	as that th igned by be detac		Diabetes melli	tus,	hyp	peslip	i dernie	~ /	10	Yes 2□ No	3 Prob	ably 4 □ Unknown
of Vital Records,	been s	ופופת	dementia	, 52	oke	, dr	onic	ym-	24a. Wes perfo	en autopsy med?	ava	re autopsy findings ilable prior to apletion of cause eeth?
l Re	0 - 0		photic levi	zem a	~			O	101	res 20 No		Yes 2□ No
Vita	clan: artific actor,	3	25. Was case referred to medical examiner?	Hospital:			10		ath (Check only o	ne)		Daughter's
	A Sign	-  -	1 ☐ Yes 2 ☑ No 27. Menngrof Death	28a. Date of	Injury	ER/Outpetient 28b. Time of	3□ DOA OT		lome 5 Aesic			Residence
ion	Attanding I ar death. ector: After by the funa	2	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year)	Injury		rk? ]Yes 2∐No		, , , , , , , , , , , , , , , , , , , ,		
Division	tal or Attanding P is after death.  al Director: After tied in by the funare		3 ☐ Suicide 6 ☐ Could not be determined		f Injury - At ho , etc. (Specify		et, factory, office		28f. Location (S City or Tox		ber or Rural	Route Number,
	within 24 hours aftar Within 24 hours aftar To the Funeral Dire completely filled in b	מוכפו	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the basi ner: On the basi and manne	is of examinati	vledge, death ion and/or inve	occurred at the ti estigation, in my	me, date and place opinion, death occ	e, and due to the ourred at the time,	cause(s) and m date and place,	anner as sta and due to	ited. the cause(s)
	within To th comp		29b. Signature and title of certifier	-MO			29c. Licen	se number		29d. Date signe	ed (Month, D	lay, Year)
					ad also the thin	00-1/7	D2.	1160		7/6/0	4	
	7	_  3	10. Name and address of person who co	. 12	Y V VV	23e) (Type, P	(e)	Balton	we t	10 21	224	
č.	State Registrar		11. Dete filed (Month, Day, Year)	32. Reg	istrer's Signat	ure L	lac		)			

DHMH 17 Rev 1/2001

State Registra

JUL 07 2004

2004

			1 - For Stete Registrar	State of Maryland			f Health an of Death	d Mental	Hygien Reg. <b>A</b>	2001	21213
į	Physic /Medi		1. Decedent's Name (First, Middle, Last BRBBRB	ANN			BIR	D ZuL	ı D	Year	
	Exami		4a. Facility Name (If not institution, give  THE 30HNS HOPK  5. Social Security Number 6. Se	street and number)  NS HOSPITAL			m, or Location of D	eath	4	c. County of Dea	ath
	Funeral Director		217-56-5640 10 Usual Residence of Decedent	□M 2 <b>M</b> F 5	6 Yrs.	Months Da		in. 8. Date of (Month	Day, Yea	0	rthplace (State or Foreign ountry)
	ours after death with the Marylan el', or Items 23a or 28a-f show Examirer must be nutified at	ector	10a. State 10b. County  MD BACT  10e. Street and Number		3AL	10f. Zip Coo	2 <i>F</i>				10d. Inside City Limits 1 ☐ Yes 2 No
	death with	Funeral Director	6802 Glenk 11. Marital Status	12. Was Decedent Ever in U.S.	13. V		21239	(Specify Yes o		US V	7
9800	72 hours after death with the Maryland "neturel", or Items 23a or 28a-f show olical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Year or Dates:		Yes, specify (	of Hispanic Origin? Cuban, Mexican, Pu No <i>Specify:</i>	erto Rican, etc.	)	Black, Whi	hite.
21215-0036	d within jiene. r than "	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give I life. E	ent's Usual Ockind of work do	ne during most of tired)	working	0	Kind of Business	
Maryland	be filed tal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last) Charles	Bird	000	111200		Name (First, Mich		n Sumame)	
-	s 1 and 2 should of Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationship (T)	Wolf	117	S. 1-0	eet and Number or	each l	DR.	Hilton	zip Code) 299 28 Hood SC
Baltimore	Page nent c ant: If ary or		1 ☐ Burial 2 Decremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature, of Funeral Service Licens	Removal from State	etery, crem	atory of other ! COA! 0 4	place) MOE/ ± 17	Date - 6-0L	1 Fax	ocation - City or	(mO)
eg T	permit. Departm Departm Importer any nju		23a. Part 1. Enter the disease or complete shock, or heart failure. List only or	aurotay	PEA	CEFUL	SYORK	ATIVE	YNON'S EUR	iun MD JERALO	PEMATION Approximate
	Prysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Hypercars  Due to (or as a consequent	ic 1		ATORY				Interval Between Onset and Death
08760,	icate be executed to physician and physician strensit on the purial-transit on the puria	al Examiner	Sequentially list conditions, any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Oue to (or as a consequent	ide of):	NCREK	TITIS				13 Days
. DOX	death certif e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	ath 3 🗆 E	Ectopic pregn <i>a</i> Other <i>(specify)</i>			and a	23d. Date of del Month	ivery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions cor	tributing to death but not resultin	ng in the und	derlying cause	given in Part I.	- 11	id tobacco	-	the cause of death?
	The ate h page	Completed						24a. W ar po 1  Ye	utopsy erformed?	prior to death?	stopsy findings available completion of cause of
DIVISION OF VITAL	Attending Physicien: The rideath. ector: After this certificate hiby the funeral director, page	tion: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2  Accident investigation		Outpatient  b. Time of Injury	28c. In	Other: 4 Nursing	eath (Check on Home 5 R 28d. Descril	esidence	6 □Other (Specify occurred	sify)
	F 0 F C	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specity)	, farm, stree				n (Street ar Town, State		ral Route Number,
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	Medical	one)	ifying Physician: To the best of my knowledge, death occurred at the time, date and place, and ocal Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.						) and manner as d place, and due	stated. to the cause(s)
	5 til 5 c c c	2	29b. Signature and title of certifier  Trace 1. Warmer	MEDICAL DOCTO	>p		.2-000		29d. Da	te signed (Month	n, Day, Year)
	b		30. Name and address of person who co				-2 000		-00		Timore,
ľ	Sta Registr	te	TRACY WANNER, JOHN 31. Date filed (Month, Day, Year) JUL 0 7 200	32. Registrar's Signature	AL, I	ower 110	3,600 No	RTH Wo	LFE S	treet, m	ARYLAND 21387

		1 - State	State of Maryland	Department of F			2001.	21211
		Registrar  1. Decedent's Name (First, Middle, Las	it)	Certificate Of	Dealli	Reg. 2. Date of Death	No. UU 4	3. Time of Death
Physic /Med		Albert )	Juane Br	ant		Month JUL	Day Year Y 1, 2004	
Exami		4a. Facility Name (If not institution, give	street and number)		r Location of Death	No. 3445 France	4c. County of Death	
		Saint Joseph			Tows	on	Balt	timore
Funera Director		5. Social Security Number 6. Security Number 193-18-24-21 Usual Residence of Decedent	PX 7. Age (In yrs. last	birthday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Col	place (State or Foreign intry) Sylvania
/land		10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits
036 We atter death with the Maryland Fig. or items 23a or 28a-f show Esst. In RETRIES IN THE PRINCE AND INCOME.	to	MD BALTIC	nore (	Cockeysvi	110			1 □ Yes 2 No
or 28	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	intry?
ath w	ī.	10708 Westca			030		USA	-
items	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
J36	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1/10 Yes 2 □ No If Yes, Give Year or Dates:	1 □ Yes 2 No	Specify:		Specify:	rite.
		15. Decedent's Ed	ucation 1	6a. Decedent's Usual Occup	ation	16b	. Kind of Business/Ir	
212 Ean 'r	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1/4or 5+)	(Give kind of work done of life. DO NOT use retired	during most of workii i)		) // /	0, 6
d 212 filed with Hygiene. ther thai		12	4. 1	Accountar			sethle ho	m Steel
0 0 0 0	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid	den Sumame)	
ore, Marylai es 1 and 2 should b of Health and Ment i itam 27 is marked r other traumatic a	2	19a Informant's Name/Relationship (7	H. Brant	IOh Mailia Adda (Oran	Dery	ra Mae	Spear.	beck.
Ma d 2 si th an th an traur		I Sa III O II I I I I I I I I I I I I I I I	rant-son 8	19b. Mailing Address (Street	100	23.2 Y	ty or Pown, State, Zi	2 Code)
re, s 1 an f Heal itam 2		20a. Method of Disposition	20b. Place	of Disposition (Name of	D	ate 20c	Location - City or T	own, State
		1 ☐ Burial 2 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State	etern compatory of their place	(a) 17 (1	al E	weed II.	11 010
Baltimore, permit. Pages 1 at Department of Hea Important: If item any injury or otherone.		21. Signature of Funeral Service Licens	EUCITIS	Funeral Char 22. Name and Add	ss of Facility	-04 P	prest Hi	71093
w For F		Kinberly O.	3anda	22. Name and Add	YORK KE	VES FUNE	RACT CLE	MATIONCIA
Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Caus. Final disease or condition		On not enter the mode of dyin	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
/Medical		resulting in death)	aDue to (or as a consequence		KLIIUN			5 MIN.
Examiner		Sequentially list conditions.	b. CORONARY AF		SE			
ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or known	Due to (or as a consequent	ce of):				
8760, cate be executed obysician and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a consequence	ce of):				
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	0		a					
Records, P.O. Box 6 The law requires that the death certifit te has been signed by the attending, age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	ath 3 Ectopic pregnancy			23d. Date of deliv Month	ery Day Year
that the ed by detac	/Ph	Part II. Other significant conditions co	intributing to death but not resulting	g in the underlying cause give	en in Part I.	23e. Did tobaco	o use contribute to t	he cause of death?
ds, lures r sign	d by							pably 4 □Unknown
Vital Records, sician: The law requires to certificate has been signer rector, page 2 should be	Completed					24a. Was an	24b Ware auto	opsy findings available
I Rec The lav ate has	d Ho					autopsy performed	prior to co death?	mpletion of cause of
	a)	25. Was case referred to medical			26. Place of Death	(Check only one)	No 1 ☐ Yes	28 No
- × × O	To B	examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 ☐ Inpatient 2 X ER/	Outpatient 3 DOA Othe	25		6 □Other (Specif	(v)
		27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b	D. Time of 28c. Injury Work		8d. Describe how in		,
Vision Attanding r death. actor: After	catio	2 Accident investigation			Yes 2 □ No			
Division  Tor Attanding after death. Diractor: After	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Ptace of Injury - At home, building, etc. (Specify)	farm, street, factory, office	2	8f. Location (Street City or Town, St	and Number or Rura ate)	al Route Number,
Hospita 14 hours Funarai	Medical C	(Check only 2 Medical Exami	rsician: To the best of my knowled iner: On the basis of examination	dge, death occurred at the tim and/or investigation, in my op	ne, date and place, and place, and place, and place, and place, and place are also as a second place.	nd due to the cause d at the time, date a	(s) and manner as s	tated.
To tha within 2 To tha comple	Mec	one)  29b. Signature and title of certifier	and manner stated.	29c. License			Date signed (Month,	
F ≯ F 8		John H A	Zem wis			1	7-02	
UX1		30. Name and address of person who co	ompleted cause of death (Item 23)		2795			000
(0)		JOHN LAVIN M. D	- 7601 OSLER	***	TKI MATERIA	AND DIC	7. /.	
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	L /	JN MARYL	AND SIS	4	
Regist	rar	JUL 07 200	14 Deniva	A sports	/			

	1	For State Registrar	State		yland / De		t of H	ealth a	and M			e	ile.	212	15
Physician /Medica	n I	1. Decedent's Name (First, Middle Franklyn Ed	wina Bı							2. Date of I Month June	23,	200		3. Time (	
Examine	l	4a. Fecility Name (If not institution 1513 Philadel  5. Social Security Number	-	Lvd.	In yrs. last birtho	Ab	erde	Location of each of the control of t	24 Hrs.	8. Date of I	Н		ord	Cour	•
Funeral Director		215-56-3287  Usuel Residence of Decedent  10a. State 10b. County	1□M 2∰F	53		Months .	Days	Hours	Min.	8. Date of 1 (Month), 12/2/	1719	50 1		Jers	
th the Maryla or 28a-f shove s notified at	Jirector	MD Hartf  10e. Street and Number			Aberde						1	itizen of W	hat Cour		s 2 No
be filed within 72 hours after deeth with the Maryland lat lygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Evarance must be notified at	runera	1513 Philadel  11. Marital Status  1X Never Married 2□ Marr	12. Was D	ecedent Eve Forces? s 2 TNo	er in U.S.	13. Was Decent Yes, spen	dent of Hi cify Cuba	spanic Orion, Mexican	gin? (Spe 1, Puerto	ecify Yes or Rican, etc.)	1	Bleck		cen Indian, etc.	
thin 72 hours e. "naturel", Medical Exa	Completed by	3 Widowed 4 Divorced  15. Deceden (Specify only highes Elementary/Secondary (0-12)	's Education t grade complete	d)	(G	ecedent's Usus live kind of wo le. DO NOT u	al Occupa rk done d se retired,	ation	t of worki	ng		Specify: Kind of Bus	iness/In		
	10 Be Con	17. Father's Name (First, Middle, Edward M.	Last)	e (1-4or 5+) LTS	S	tocke:				(First, Midd	lle, Meide	n Sumame		t Mer	chang S
It. Peges 1 end 2 of the control of Health ar trant: If item 27 is njury or other trau		19a. Informant's Name/Relations Sonja J. Brow 20a. Method of Disposition 1 □ Burial 2 □ Cremation 1 □ Donation 5 □ Other (S.) 21. Signature of Funeral Service	n —Daug ₃ □Removal fro	m State	151 20b. Place of Di	crematory or c	lade ne of other place Sch	elphi	a B 6/2	lvd.  0ate  5/04	Abe 20c. Wa	rdeer Location - C shing	i, N City or To	MD 21 own, State	;
Physician /Medical Examiner	cal Exa	23a. Pert1. Enter he disease, or shock, or eart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or influry that initiated events resulting in death) Last	a	to (or as a co	consequence of):	3821 anter the mod	14th le of dying	$\mathrm{ST}$ , g, such as	N .	stin W. WI or respiratory	C 2	0011	Ful	Approxima Interval Be Onset and	ate etween
The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Pnysician/medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩No 9 □ Unknown		e birth 2 [ egnant at time	Fetel death	3 ⊟Ectopic pi 5 □ Other (sp						23d. Date Mont		əry Day	Year
equires that	2	Part II. Other significant condition	ns contributing to	death but r	not resulting in th	e underlying o	ause give	n in Part I.		111 .	Α			he cause of pably 4	
n: The law in Tricate has b	e completed	25. Was case referred to medical						00 Binne		pe	lopsy formed? 2 2 N	pri	or to co ath?	psy findings mpletion of 2000No	available cause of
hysici hysici this cer al direct	0	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendin  2 Accident investit  3 Suicide 6 Could	g 28a. Da (M)	□ Inpatient te of Injury onth, Day Y	'eer) 28b. Tim Inju	e of 2	8c. Injury Work 1 🗆 Y	r: 4□ Nu	rsing Hor	ne 54 Re 28d. Describ 28f. Location	sidence e how int	ury occurred	d		nber,
dospitel or t hours afte unerel Dir	edical Cert	4 Homicide  29a. Certifier   1×3 Certifyin   (Check only 2 Medicel	g Physician: To Examiner: On the	the best of rebassis of ex	ny knowledge, d	eath occurred	at the tim	e, date an	d place, a	and due to th	e cause(	s) and man	ner as si	tated.	(s)
To the P within 2. To the F complete	Med	29b. Signature and title of certifie	and m	anner state	d.		License		177	7)		ate signed			
State	e	30. Name and address of person  31. Date filed (Month, Day, Year)	who completed can me	ause of deal	1650		ins	Stree	of 5	Paltin	1019,	Mar	ylar	ad 21.	23/
Registra		JUL (	7 2004	1000	ORIG	Aces INAL									

			1 - For Stete Registrar	State of Marylan			of Health and of Death	Mental I	Hygien Reg. N		21216
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last)  Kenneth A  4a. Facility Name (If not institution, give s	Brittain street and number)		4b. City, Tow	m, or Location of Dea	2. Date of Month	٥	c. County of De	1 4140 P
	Funeral		Baltinor Rehabilta 5. Social Security Number 6. Ser 219-28-6525	tion Extended C	last birthday)	If Under 1 Y	Himere ear If Under 24 Hr ays Hours Mir	. (Month	, <i>Day</i> , Ye <i>a</i>		sirthplace (State or Foreig Country)
The state of	Director	or	Usual Residence of Decedent  10a. State	10c. City	y, Town or Lo		le River	Oct.	5 19	32 Ma	10d. Inside City Limit
100	n with the Marylar 39 or 28e-f show st.be notified at	Funeral Director	10e. Street and Number 132 Sylvan Ave			10f. Zip Cod			10g. 0	Citizen of What	
	is 1 and 2 should be lied within 1.2 hours after death with the maryia of Health and Mental Hygiene. I field 21 is marked other than "neturel", or Items 23e or 28e-f show other treumatic event, the Modical Examilitation at the multiply at	þ		12. Was Decedent Ever in U. Armed Forces? 1 [\$\fomale{X}\text{Yes} 2 \subseteq \text{No} if Yes, Give Year or Dates:			of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or rto Rican, etc.			
1 7	od within /z no giene. er than "netur , the Modical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 8th	cation o completed) College (1-4or 5+)	16a. Dece (Give life. Boi]	dent's Usual Oc kind of work do DO NOT use re er Op	ccupation one during most of w etired) erator	orking		Kind of Busines	•
	Z should be filled with and Mental Hygiene, is marked other that eumatic event, If a h	To Be C	17. Father's Name (First, Middle, Last)  Charles Brit  19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (St.	18. Mother's Na Flo	rence	M. 1	Вау	, Zip Code)
	rages I and 2 somet of Health ar not: If item 27 is iry or other treu		Kathy Weimenn / 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ R	daughter	518 lace of Dispo	Dorse	y Ave. B	altimo Date	ore I	MD 212 Location - City	21 or Town, State
	Department of Important: If any injury or once.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License			2. Name and A	metery 7  ddress of Facility C  0 Mace A	onnel	lyFu		omeofEsse
E	/Medical /Medical eparage and parial-Itansii	cal Examiner	23a. Part1. Enter the disease, or come is shock, or heart failure. List prity or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or karry that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):	er the mode of	dying, such as cardi	ac or respirato	ry arrest,		Approximate Interval Between Onset and Death
The state of the s	man me deam centification of the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of di	death 3	Ectopic pregn			_	23d. Date of d Month	elivery Day Year
and order	w requires man been signed b should be deta	by	Part II. Other significant conditions cor	tributing to death but not rest	ulting in the u	nderlying cause	e given in Part I.	- 1	oid tobacco		to the cause of death?  Probably 4 □Unknov
		Completed						a p 1 □ Ye		prior to death	autopsy findings availab o completion of cause of es 2 No
- diam Dhuniain	After this funeral di	ation: To Be	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c.	26. Place of Do Other: 4 Nursing Injury at Work? 1 Yes 2 No	Home 5 P	lesidence	6 ☐Other (Spury occurred	ecity)
major and the first of	volue nospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	I Certification:	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	′)			City or	Town, Sta	te)	Rural Route Number,
To the Handanian	vithin 24 hours after To the Funerel Direct completely filled in by	Medical	(Check only one)  2 Medical Exemination (Check only one)	ner: On the basis of examinal and manner stated.	tion and/or in	vestigation, in r	my opinion, death occurrence	curred at the tir	ne, date a	nd place, and di	ue to the cause(s)
ř	7 × 3 × 8			Call.	m.D	. 3	4359(0	Com			
	Sta	ite	30. Name and address of person who co S. LAH, M.D. 3 31. Date lifed (Month, Day, Year)	mpleted cause of death (Item 900 Lock Rave 32. Registrar's Signa	1301/20 1301/20	vard, Be	Stimore,	maryl	and	21218	

DHMH 17 Rev 1/2001

ORIGINAL ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year BAKER EVANGELINE JULY 2004 /Medical If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-27-1928 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BON 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Months 217-24-6701 Director VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Mudical Examiner must be notified at Yes 2 No Director MD N/A **BALTIMORE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1905 RIGGS AVENUE 21217 or Itams 23a USA by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK 3X Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 HOUSEKEEPING HOTEL Pages 1 and 2 should be filed nent of Health and Mental Hygi ant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MCKINLEY HARRIS GLADYS WALKER ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES BAKER/SON 1905 RIGGS AVENUE BALTIMORE, MARYLAND 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of H Important: If ite any injury or ot 1 XBurial 2 Cremation 3 Removal from State MT ZION CEMETERY 7-6-2004 BALTIMORE, MARYLAND ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee ames morton 1701-31 LAURENS ST. BALTIMORE, MARYLAND 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician OF /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy ō Month 4 Pregnant at time of death 5 Other (specify) o the 9 Unknown signed by a detache 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Wonknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 1 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA ٩ 1 ☐ Yes 2 No this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Diractor:
completely filled in by the 6 Could not be determined 3 🖺 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THomas MILLER BON SECOURS BALTIMENTE 31. Date liled (Month, Day, Year, 32 Registrar's Signature State Registrar 0 7 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner het hirthday) If Under 1 **Funeral** 9 Birthplace (State or Foreign Country) 1**X** M 2□F Yrs. 14+56-0621 Director Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examinar must be notified at Director MARULAND 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code g. Citizen of What Country? by Funeral 45 Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filled within 72 hours after or the of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PT. OF PUBLIC WORKS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be STER MOOT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is DARLENE THOMA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) = 5 Department of Important: If any injury or once. <sup>¹</sup> 4 □ Donation 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. the as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy jo in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4XUhknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 **1**0 2 K R 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 Mo 1 Anpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Katural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name 32 Registrar's Signature State JUL 0 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day **Physician** 155PM 2004 eorgia /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner tospita Denera lanc 7. Age (In yls. last birthday, 5. Social Security Number 9 Birthplece (State or Foreign Country) **Funeral** 218-14-7524 Usual Residence of Decedent 1□M 2XF Director 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or Itams 23a or 28e-f show the Medical Exertiner must be notified at 15 Yes 2 □ No Directo Maryland more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If item 27 is marked other than "any highry or other traumatic event, the Magnes. College (1-4or 5+) Elementary/Secondary (0-12) Home ounselor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nam stionship (Type, Print) Joann 10. 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 Removal from State 12004 10 Mem. 4 ☐ Donation 5 ☐ Other (Specify) ark 22. Name and Address of Facility 21. Signature of Funeral Service Licensee oseph uzer Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Tentoni **Physician** /Medical Due to (or as a consequence of) **Examiner** Forat duentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of) ed by the attending physicien detached for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 € No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed by Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 3 Probably 4 Denknown 1 Tyes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe this certificate 1 Yes 2 10 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 Z No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation To the Function of the Function of the Function of the Function of the functio 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated Tothe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Eduardo Mirelos 440 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

BRIGIOS, GRORGIAMI

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State # 23a,27,  1. Decedent's Name (First, Middle, La		E,G83	4,892	g <i>p</i> g4e pf l	Death	2. Date of De		U4	3. Time of Death
	Physici /Media		Caroline	М.			Blaney		July	Ol,	2004	16:50 M
	Examir	er	4a. Facility Name (If not institution, given Anne Arundel Med				4b. City, Town, or Annap	Location of Deat	th		nty of Death Inne Ar	undel
in the second	. Funeral Director		5. Social Security Number  551-23-3243  Usual Residence of Decedent	3.2	In yrs. last 44		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th ly, Year) , 1959	9. Birthol Count Texa	ace (State or Foreign try) 3.S
	yland yland		10a. State 10b. County	10	0c. City, To	own or Loca	tion				10	Od. Inside City Limits
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21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 Is marked other than "natural", or Itams 23c or 28a-f show other traumatic avant. Its Madical Examinat must be notified at	d by Funeral Director	1 Never Married XXMarried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:			es, specify Cuba ☐ Yes 2 No	n, Mexican, Puer Specify:	to Rican, etc.)	Spec	tack, White, e cify: Wh	nite
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Baltimore, Maryland	Page ment tant: It		*4 Donation 5 Other (Specify)  Hillcrest Cemetery 7/  21. Signature of Funeral Service Cemetery 22. Name and Address of Facility						2004	Annapo	lis, M	D
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^		-	30. Name and address of person who	completed cause of death	Stem 232	(Type Dri		/•C•l'1•E•		oury (	75, 200	J* <del>1</del>
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	/Media		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death	July	4c. County of Dear	
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ă	atte d for	cia	in the past 12 months?	3 ☐Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
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3e	has has	mp				24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
<u>=</u>		O						2 No
<u>Ş</u>	Physician: T this certifical al director, p	Be	25. Was case referred to medical examiner?	Other	8. Place of Death (6	Check only one)	2.	
of	Phys this aldi	To	1 Inpatient 2 EH/Ou	tpatient 3 DOA			ce 6 Other (Spec	cify)
n		lon	1 Matural 5 Pending (Month, Day Year) II	njury Work?		d. Describe how	injury occurred	
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$\leq$	in Sire	rtif	4 Homicide determined 288. Place of Injury - At home, fa	rm, street, factory, office	281	City or Town,	et and Number or Ru State)	iral Houte Number,
_	Hospital		200 Contillor 1 A Continue Thursdain w	4-4	1			
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	ledical	29a. Certifier  (Check only one)  1 Check only one)  1 Medicel Examiner: On the basis of examination an and manner stated.	d/or investigation, in my opinio	on, death occurred	at the time, date	and place, and due	to the cause(s)
	o the ithin ( o the	Mec	29b. Signature and title of certifier	29c, License nu	ımber	204	L Date signed (Month	Day Year!
<b>)</b>	F ≯ F 8		mus on	DO	74412	230	62 m	- 2
7	1		, July	7 3	(171)		01-06	-2004
	V\		30. Name and address of person who completed cause of death (Item 23a) (	Type, Print)	Bor Oti-	MATO	MD 71	77.
		10	and manner stated.  29b. Signature and title of certifier  Mue—MD  30. Name and address of person who completed cause of death (Item 23a) (  OUNG J. Let 300 5 . Ho  31. Date filed (Month, Day, Year) 32. Registrar's Signature	10000		inuce	int a	005
	Sta Registr	_	JUL 0 7 2004	sparker				
		10	/ /					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Castro State of Maryland / Department of Health and Mental Hygiene 04 - 43351 - For State Registrat Certificate of Death AKG 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** C'ASTKO OHN July 2, 15:18 P M 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Fort Washington Fort Washington Medical Center Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 100 M 2□ F 33 054 58 1025 Director New Usual Residence of Deceden 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28e-f ehov other traumatic event. The Medical Exertiner must be notified at BrONX 1 Nes 2 □ No BrONX Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rusedale 1506 10460 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🐧 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry UNK al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Security Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental P CASTIO JIMINEZ Felix 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CASTro Kosedale if Health Denise 1506 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 0 = 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ď 10 Department of Important: If any injury or once. Browx, N. KAYMONds 22. Name and Address of Facility 21. Signature of Funeral Service Licenses a. Morton And SUND FINISHIHA ams Baltman (MD) 1701 Laneans St 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Cher (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 24 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

✓ Yes 2 □ No 24a. Was an autopsy performed 2 ☐ No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 XYes 2 ☐ No 1 Inpatient 2X ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. D. te of Injury (1 onth, ay Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 104 1 Tyes 2 Accident after death Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, lace of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide ی within 24 hours a To the Funerel L pellil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time date and place, and due to the cause(s) and manner as stated.

1 Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time date and place, and due to the cause(s) and manner as stated.

2 Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time date and place, and due to the cause(s) and manner as stated.

2 Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar

31. Date filed (Month, Dav. Year)

7 2004

32 Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

O.C.M.E.

July 3, 2004

111 Penn Street, Baltimore, Maryland 21201

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			<b>1</b> _ For Steta	State	of Marylai						lental ⊢	lygier	ne	. 1	
			Ragistrar	4		Cei	rtificate	e of L	Jeath		0.001	Reg. I	No.	14	21224
	Physici	an	Decedent's Name (First, Middle,			_					2. Date of Month		Day	Year	3. Time of Death
	/Media	al	A. C. 19 Mars (6		ndra Del	Cesar:			1 0		July		2004	(5)	12:20 P <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution,	•	-				Location of	of Death			4c. County		1
			Joseph Ritchie  5. Social Security Number	HOSPICE 6. Sex	7. Age (In yrs	last hirthday)	If Under		If Under	24 Hrs.	8. Date of	Rinth		N/A	eplana (Chata as Familia
	Funeral Director		216-54-2761	1□M 2√2F		Yrs.	Months	Days	Hours	Min.	reb.	Day Ye	1950	COL	nplace (State or Foreign untry) Yyland
			Usual Residence of Decedent												-7
	yland		10a. State 10b. County			ity, Town or Lo	cation								10d. Inside City Limits
	a-fst	ţō	Maryland	Baltimor	e				Dun	da1k					1 □Yes 2 🐴 No
	h the	irec	10e. Street and Number				10f. Zip	Code				10g. (	Citizen of W	/hat Coi	untry?
	th wit	a D	7866 Charlesm	ont Road	l				21	222		τ	Jnited	l st	ates
	within 72 hours after death with the Maryland ene. Than "neturel", or flems 23e or 28a-f show he Madical Examinar must be motified at	Funeral Director	11. Marital Status		ecedent Ever in U Forces?	J.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or Rican, etc.)	No-		- Amer	ican Indian,
9	or ft	F	XX Never Married 2 ☐ Marrie		s 2 No		1 □ Yes 2		Specify:	.,			Specify		
21215-0036	ureľ,	d by	3 Widowed 4 Divorced	Year or	Dates:								Specify		White
5	"net	Completed	15. Decedent' (Specify only highes		d)	(Give	dent's Usua kind of wor	k done a	lurina mos	t of worki	ing	16b.	Kind of Bu	siness/l	ndustry
12	withir	mp	Elementary/Secondary (0-12)	College	(1-4or 5+)		<i>DO NOT us</i> Lalist			Cu	etome	-	[mport	-c /	Exports
N	Hygie Hygie Sther	ပိ	12 Years 17. Father's Name (First, Middle, L	ast)		Spec.	Latible	- 101			First, Midd	1			EXPOLES
⊆	2 should be filed withir and Mental Hygiene. Is markad other than eumetic event, Ite M.	Be	Dolphi Cesari	•							Johnso		en Sumam	6)	
2	should nd Men marka umetic	ဥ	19a. Informant's Name/Relationsh			19h Mailir	ng Address	/Street a			l Route Nur		v or Tourn	State 7	in Codol
<u>≅</u>	d 2 s than than 7 is i		Mrs. Lois Hughe		<u>:</u>		Cres				ndalk,				1222
	rit. Pages I and 2 should be filed within 72 hours after death with the Marylan cartinent of Heath and Mantal Hygiens cardinent of Heath and Mantal Hygiens or creent; if tem 23e or 28e-f show njury or other treumetic event, the Madical Examinar must be motified at a general process.		20a. Method of Disposition		20b.	Place of Dispo				0	ate	20c.	Location -	City or 1	own, State
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臣	permit. Pages Depertment of Impertent: if i any njury or o		<ul> <li>4 □ Donation 5 □ Other (Sp</li> <li>21. Signature of Funeral Service L</li> </ul>												
Ba	Deporting on the second of the		21. Signature of Furieral Salvice E	2	>						Home o				
			23a. Part1. Enter the disease, or	complications tha	t caused the dea						ndalk,		cyland	1 21	
			shock, or heart failure. List of Immediate Cause (Final	inly one cause or	each line.	1 -0-	or the mode	n n	j, sucirus i	i		,			Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a	Melas	stalic	en	don	set r	ial	can	CRY			> 1 year
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m	death s atte d for	Cia	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pre	e birth 2 □Fet gnant at time of (		]Ectopic pre ] Other <i>(sp</i> e						Mon		Day Year
0	t the	hys	9 Unknown	9□Unl	known										
٦,	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	by P	Part II. Dther significant condition	ns contributing to	death but not re	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Di	d tobacco	o use contri	bute to	the cause of death?
rg.	quire an sig uld b										1[	Yes	2□No	3 🗌 Pro	bably 4 Unknown
Records,	sw requir s been s	Completed									24a. W		24b. W	ere aut	opsy findings available
R	The lav	mo									pe	topsy normed 2 1 h	✓ d	eath?	ompletion of cause of
		a	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes		10	☐ Yes	2 No
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1 0	g Ph ler th	n: T	27. Manner of Death	28a. Dai	te of Injury onth, Day Year)	28b. Time of		Bc. Injury Work	at	-	28d. Describ				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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Division	or Attendated after deatler deatler birector:	tific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determine	200. Pla	ce of Injury - At h	nome, farm, str	eet, factory,	office		2	28f. Location	(Street a	and Numbe	r or Rur	al Route Number,
Ō	s after s afte	Certification;		001	iding, etc. (opec	'97					City of 1	0411, 012	110)		
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Medical	one)	and ma	anner stated.	ation and or in	vestigation,	in my op	mon, deal		o at the tim				
	To To I	2	29b. Signature and title of certifier					License					ate signed		
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	10		30. Name and address of person v	no completed ca	use of death (Ite	m 23a) (Type,	Print)		1	01	0	11.	1	4 1	004
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: -	Sta Registr		31. Date filed (Month, Day, Year)		Registrar's Sign	ature .	1								

SANDER CREARINI

		For	State of Maryland			Mental Hy	giene	
	l		M #12 PER FH G833	Certificate	of Death		Reg. No. 1)	21225
Physician		Decedent's Name (First, Middle,		Quartile.	0 70	2. Date of De.	Day 2004	3. Time of Death 8:22Р. м
/Medica Examiner		a. Facility Name (If not institution,		RUTCHE 4b. City, To	wn, or Location of Dea		4c. County of Death	0.221.
	ı	501 PENNSYLVANI	A AVE	BALT	TIMORE		N	A
Funeral		and an anna	6. Sex 7. Age (In yrs. las		Year If Under 24 Hr Days Hours Mir	n. (Month, Da	h y, Year) 9. Birth	place (State or Foreign
Director		122-52-7221	61	trs.		JUNE 1	6,1931 AL	ABAMA
ryland		0a. State 10b. County	10c. City, T	Town or Location		~		10d. Inside City Limits
with the Marylan o or 28e-f show be notified at		MARYLAND .	NIA		4LTIMO	RE CI	TY	1 XYes 2 □ No
e or 2		Oe. Street and Number	7- 1111-111111	10f. Zip Co	ode 7 A 3	1	10g Citizen of What Cou	ntry?
of the death with the state of		1. Marital Status	12. Was Decedent Ever in U.S.	13. Was Deceden	t of Hispanic Origin?	Specify Yes or No	14. Race - Americ	can Indian
036  ours after death with the Maryla el', or items 23e or 28e-f shov  Exertine frout be redified at by Finneral Director		1 Never Married 2 Marrie	Armed Forces?  MY Yes 25000  If Yes, Give	If Yes, specify	t of Hispanic Origin? ( Cuban, Mexican, Pue	erto Rican, etc.)		
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or items 23e or 28e-1 show not. The Medical Examinat must be redified at a Completed by Filingral Director.		3 ☐ Widowed 4 ☑ Divorced	Year or Dates:				Specify: 81	ACK
121215-00 led within 72 ho ygiene. ner than "neturn it, the Medical Completed	_	15. Decedent' (Specify only highest	grade completed)	16a. Decedent's Usual C (Give kind of work of life. DO NOT use r	done during most of w	orking	16b. Kind of Business/In	dustry
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be file hall Hy od othy event.		7. Father's Name (First, Middle, L			18. Mother's Na	ame (First, Middle,		
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0 % = 5		1 ☐ Burial 2 ☐ Cremation  `4 ☐ Donation 5 ☐ Other (Sp	3   Indemoval from State   -	ASANT GROVE		08-04	ATHENS, AL	ABAMA
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O. Box 6 he death certifi the attending the for use as			23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	eath 3 Ectopic pregn			23d. Date of delive Month	ery Day Year
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	·		ate of Maryland / Dep	partment of Health and Mertificate of Death	lental Hygie		21226
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Jos	eph S. Cassells		2. Date of Death Month	Day Year 2004	8:00 A M
Examine		4a. Facility Name (If not institution, give street 6615 Rannoch Road	and number)	4b. City, Town, or Location of Death Bethesda		4c. County of Death  Montgome	ry
. Funeral Director		5. Social Security Number 6. Sex 1 図 M 3 Usual Residence of Decedent	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Nov. 9, ]	9. Birthp Court 1934 South	place (State or Foreign htry) n Carolina
Maryland -f show lied st	tor	10a. State 10b. County  Maryland Montgomery	10c. City, Town or	Location		1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
ath with the Maryla 23a or 28a-f shoust be notified at	Direc	10e. Street and Number 6615 Rannoch Road		10f. Zip Code 20817		Citizen of What Coun	
er des	by Funerai	1 ☐ Never Married 21☑ Married 11☑	as Decedent Ever in U.S. med Forces? ☑ Yes 2 ☐ No Yes, Give ear or Dates: 1959–1988	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ Black, White, Specify: Whit	ean Indian, etc.
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 77 le marked other then "netural", or treumatic event, the Madical Exami	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	pleted) 16a. Dec (Gir ilfe	cedent's Usual Occupation ve kind of work done during most of work . DO NOT use retired)	ing 16t	o. Kind of Business/Ind	
and 21 be filed winter the other the	Be	17. Father's Name (First, Middle, Last)	5+ Phys		e (First, Middle, Maid	J.S. Navy	
ire, Marylanc s 1 and 2 should be f f Health and Mentar item 27 te marked of other treumatic eve	ဠ	Samuel Cassells  19a. Informant's Name/Relationship (Type, P		Azilee iling Address (Street and Number or Run	al Route Number, Ci		- 1
e 1 an 1 an 1 an 1 an 1 an 1 an 1		Judith M. Cassells/W  20a. Method of Disposition  1 □ Burial 2 ▼Cremation 3 □ Remove  1 □ Donation 5 □ Other (Specify)	20b. Place of Dis	Rannoch Road, Bet position (Name of rematory or other place) y Crematorium  July 20	Oate 200	. Location - City or To	own, State
Baltimor		21. Signature of Funeral Service Vicensee	M00198 B	22. Name and Address of Facility Rob ethesda-Chevy Chas Betnesda, Mary	ert A. Tui	thesda, Ma mphrey Fun 7557 Wisco 4-3501	eral Home/ nsin Avenue
Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	ns that caused the death. Do not ease on each line.  Pancreatic Cano Due to (or as a consequence of):	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death 1 months
Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Jases Causa) (Jases Caus	Due to (or as a consequence of):				
De de de de de de de de de de de de de de	cal Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):				
OX 68 th certifica ending ph	Physician/Medl	in the past 12 months?		B □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ory Day Year
rds, P quires that n signed b	by	Part II. Other significant conditions contribut	ing to death but not resulting in the	underlying cause given in Part I.		co use contribute to th	
Vital Records, sicien: The law requires the certificate has been signed rector, page 2 should be on the certificate has been signed to be signed.	Completed				24a. Was an autopsy performed 1 Yes 2	prior to con death?	psy findings available appletion of cause of
f Vital F	Be	25. Was case referred to medical examiner?	al:		(Check only one)		
In a fitter	tion: To	T Tes 25 No	a. 1 ☐ Inpatient 2 ☐ ER/Outpati a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	me 51 Residence 28d. Describe how in		9
Division  To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attencompletely filled in by the fune.	Certification:	a Could not be	e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	Route Number,
he Hospit n 24 hour he Funere pletely fille	edical	(Check only 2 Medical Examiner: (	To the best of my knowledge, deal on the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as stand place, and due to	ated. the cause(s)
X	Σ	29b. Signature and title of certifier	12	29c. License number 154231 MA		Date signed (Month, L July 2, 20	**
151		30. Name and address of person who comple Jennifer Crook, M.D.	National Naval	<sub>e, Print)</sub> _ Medical Center, B	ethesda, l	Maryland 2	0889
Stat Registra	100	31. Date filed (Month, Day, Year)	32. Registrar's Signature	rach			

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

					Oldio ol	ivial y la		tificate of		d Mental H	Reg. Nó		0	1007
	Dharaini		1. Decedent's Name (First, Mi	ddle, Les						2. Date of I	Death Da	y Yea		Time_of Death
	Physici /Medio		Lovinia	ł	(volc		_			June	2	7200		pm
	Examin		4a. Facility Name (If not institu	tion, give	street and numb	per)			4b, City, Town,	or Location of De	ath 4c	. County of De	eath	
			Roland Park	Plac	e				Balti					
ı	Funeral Director		5. Social Security Number 234–14–9934	6. S	ex	. Age (In yrs 88	. last birthday) Yrs.	If Under 1 Year Months Days	Hours N	Hrs. 8. Date of I Win. Jan 1	$\frac{\text{Birth}}{\text{Day}, Year}$	16 N	Sinthplace ( Country) SW YO	(State or Foreign rk
	and w		Usuel Residence of Decedent 10a. Stete 10b. Cou	ntv		10c. C	ity, Town or Lo	cation					10d. In	nside City Limits
	Maryl f sho	o	MD					imore						X Yes 2 □ No
	r 28a	<u>i</u> e	10e. Street and Number					10f. Zip Code			10g. Cit	izen of What	Country?	
	th wit	Funeral Director	830 W. 40th	Stre	eet			21	211			USA		
	dea	ner	11. Marital Status		12. Was Deced	ent Ever in U	J,S. 13. \	Was Decedent of H	lispanic Origin	? (Specify Yes or I	No-	14. Race - Al Black, W		dian,
Maryland 21215-0020	hours after death with the Maryland tural', or Itema 23a or 28a-f show al Evantinet must be notified at	þ	1 ☐ Never Married 2 🔀 N 3 ☐ Widowed 4 ☐ Divord		1 ☐ Yes 2 If Yes, Give Year or Date	No No		1 □ Yes 2 X No		dono modin, oto.,		Specify:	white	е
5-0	72 ho	Completed	15. Deced (Specify only hig	lent's Ed	ucetion de completed)		16a. Deced	lent's Usual Occup	ation during most of	working	16b. K	ind of Busine	ss/Industry	,
121	ithin de la la la la la la la la la la la la la	n p	Elementary/Secondary (0-12		College (1-4	lor 5+)	- life. I	kind of work done OO NOT use retire		Working				
2	led w lygier her th	ខ	12	4- (4)	2			homema		Name (First, Midd	Un Adairda	own ho	me	
anc	ntal H ed otl	Be	17. Father's Name (First, Midd John Roy Mac		l an					, ,		,		
Z	hould d Me merk metic	၉	19a. Informant's Name/Relation				19b Mailir	g Address (Street		rence Ra			Zin Code	a)
Z	than then		Roland Park					W. 40th						7
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural; or itema 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematic 4 ☒ Donation 5 ☐ Other				Place of Dispo	sition (Name of natory or other pla		Date	т —	ocation - City		itate
Baltii	permit. F Departmi importar any injur		21. Signature of Funeral Servi			regto		Name and Addre			I. Ba	ltimor	e Str	eet
		-	23a Part1 From the disease	or com	plications the cau	ised the dea		altimore,		1201	errest		Appr	rovimate
	Physician	1	23a. Part1. Enter the disease shock, or heart failure.	ist only	one cause on eac	h line.	20		.,,	,	311001		Inter Onse	roximate val Between et and Death
N. Carlotte	/Medical		Immediate Ceuse (Finel disease or condition			D	nair	nonia					1 1 1	wall
	Examiner		resulting in death)		a	-	or es e conseq			11 * - 2,0				io ac
	י מי	iner			h								i	
	tificate be executed g physician and es the burial-transit	edical Examiner	Sequentially list conditions,	ſ	0.	Dua to (	ut as a culised	uarica of).						
60,	be ey	<u>е</u> Ш	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Į	c								-	
68760,	lificate be execul g physician and es the burial-trar	ed c	resulting in death) Last	1		Due to (	or as a conseq	uence of):					į	
Box (		-		•	d								1	
	death e ette d for	cia	Pert II. Other significant cond	itions co	entributing to deat	h hut not re	sulting in the u	nderlying ceuse giv	ren in Part i	23h Di	d tobacco	use contribu	te to the c	cause of death?
P.0	The law requires that the death cert ate has been signed by the ettendin page 2 should be detached for use	by Physician/N							ì		∃Yes 2			4 ☐ Unknown
	ss tha gned be de	by P	bsti	id	umum	(I) YE	tho W	) (U)	1115	_				
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S	law n as be	Completed		3				1,1	3361				of death	ion of cause ?
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/ita	ysician: s certific director,	Be	25. Was case referred to med examiner?	F-	114-1				-	Death (Check only	one)			
of \	Physician: r this certific rel director,	2	1 ☐ Yes & No		-		ER/Outpatien		Nursin	ng Home 5 □ Re			ecify)	
E C	0 0 0	lon	27. Manner of Death  ↑□ Natural 5 □ Pen	ding stigation	28a. Date of (Month,	Day Year)	28b. Time of Injury	28c. Injur Wor M 1 □	yet k? Yes 2 □ No	28d. Describ	e now injui	ry occurred		
İSİ	Attending ir death. sctor: After by the fune	ficat	3 ☐ Suicide 6 ☐ Cou	_		Injury - At h	nome, farm, str	eet, factory, office	163 2 110	28f. Location	(Street an	nd Number or	Rural Rou	te Number.
Θ	or A effer Direct	Certification:	4 ☐ Homicide	Butuned	building	, etc. (Speci	fy)	oot, lastery, emice			own, Stete			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: Aft completely filled in by the fun	edical C	29a. Certifier Certification (Check only one)	ying Phy al Exam	rsician: To the be iner: On the basi and manne	is of examina	owledge, death ation and/or inv	occurred at the tir restigation, in my o	ne, date and pl pinion, death o	ace, and due to the	e ceuse(s) e, date and	and manner d place, and d	as stated. ue to the c	ause(s)
	ro the within ro the	Me	29b. Signature and title of cert	fier	-			29c. Licens				te signed (Mo		
	0		WILM!	L LA	Dn 1	MO			D35	102	lu	n: 2	8, 2	2004
			30. Name and address of pers	on who o	completed cause	of death (Ite	m 23a) (Type,	Print) , \	0	1 0	-			1
			Hilan Do	n n	100000000000000000000000000000000000000	40	Tur	br.du	E KUR	14 BAI	nno	of M	AN	IANO
	Sta Hegistr		31. Date filed worth Day, 2	104	E BE	s Sign	D 1	ook		ad Bal				

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ng 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** IOHN APERS 12:10 Am 2004 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number, 4c. County of Death Examiner RANDALLSTOWN GENESIS ELDERCARE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F Yrs. 72 Director 217-24-7291 Usuel Residence of Decedent MARCH 1, 1932 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director MD NA BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1310 LAFAYETTE USA AVENUE W. 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2K Married 1 XYes 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: AFRICAN Specify. 2 lf Yes, Give Year or Dates: 3 Widowed 4 Divorced AMERICAN Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MAINTAINENCE DEPT WELDER 10th17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Surname) Be JAMES CAPERS VURLEY MCPHERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAPERS BARBARA J. (WIFE) W. LAFAYETTE AVE. BALTIMORE, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VET. CEM 7/8/04 OWINGS MILLS, MD 22. Name and Address of Facility WYLIE FUNERAL HOME PA 21. Signature June 11 Survice Licensee 638 N. GILMOR STREET BALTIMORE, MD 23s. Parl 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** CORONARY ARTERY DISEASE /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner or Attending Physician: The lew requiras thet the death certificate be executed use es tha buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐₩ñknown EMENTIA Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? HYPERTENSION completion of cause of death? DISEASE PERIPHERAL VASCULAR 1 You 2 10 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this within 24 hours after deeth.

To the Funeral Director: After this complately filled in by the furieral 28b. Time of 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier D0059107 07-04-2004 M. D 2600 LIBERTY MEIGHTS AVENUE 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) UMA MEDICAL GROW BALTIMIRE MD 21215 WESTSIDE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

0 7 2004

State Registrar

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M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 07 2004

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

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07/02/04

TAKOMA PARK MD

Division of Vital Records, P.O. Box 68760,

7610 CARLOLL

		•	For State Registrar	State of Ma		partment of Hertificate of L			giene	04	21230
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}	Examir Funeral	er		NA Medi	e (In yrs. last birthda	340	Location of Death  ////  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day	K	y of Death	ace (State or Foreign
	Director		214-30-8350  Usual Residence of Decedent  10a. State 10b. County	1□M 2⊠F	71 Yrs.		Hours Min.	1-10	-33	Maryl	and d. Inside City Limits
	the Marylan 28a-f show	Director	Maryland Some	erset		Princ	ess Anne		10g. Citizen of		1 ☐ Yes 2 ☑ No
	eath with s 23s or must be	Funerai Di	10449 Bluebird I	rive	Ever in 11 S 13	2	21853			USA	
9800	ours after d iral', or Itam Examinati	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces?  1  Yes 2  New Year or Dates:	No To	8. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ঐ No	Specify:	Rican, etc.)	Special Special	ick, White, et Whit	tc.
3altimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to fleath and Mental Hygiene. I of Heath and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23a or 28a-f show of item 27 is marked other than "natural", or Itams 12a or 28a-f show or other traumatic evant, the Modical Exatt fact must be notified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Giv	edent's Usual Occupa re kind of work done of DO NOT use retired Senior A	luring most of worki )		16b. Kind of B Multi-S		Senior Center
yland ;	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic evant, the Med	Be	17. Father's Name <i>(First, Middl</i> e, Las Walter Mahan				18. Mother's Name		Maiden Sumai		
, Mar	and 2 shi salth and 27 is m er traum		19a. Informant's Name/Relationship Bonnie Martin (Da			lling Address <i>(Street a</i> 151 Bluebi			-		
more	Pages 1. ient of He nt: If iten ry or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 [  '4 ☐ Donation 5 ☐ Other (Speci		1	position (Name of ematory or other place ethodist Ceme	θ)		20c. Location Rehobet	•	•
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice Mary Beth Br	Biodhoun adshaw-Pru		Name and Address Brdashaw 306 W. Ma	Sons Fu	neral H	ome		
	In private the property of the private that the private t	dicai Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a ACV Due to (or as b Due to (or as c.		UE ANN				I.	Approximate Interval Between Onset and Death  A44 J
P.O. Box 68	The law requires that the death certific. Ite has been signed by the attending pl age 2 should be detached for use as t	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	☐ Ectopic pregnancy				ate of delivery onth D	r Year
	equires that en signed b	ed by P	Part II. Other significant conditions	contributing to death bu	ut not resulting in the	underlying cause give	en in Part I.		bacco use con es 2□No	tribute to the	cause of death?
Vital Records,		Complet						24a. Was a autops perforr	med?	prior to comp death?	y findings available pletion of cause of
of Vita	Phyaician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2  Mo	Hospital: 1 Inpatie	ent 2 ☐ ER/Outpatio	ent 3 DOA	26. Place of Death			ner (Specify)	
Division o	fing After fune	Certification;	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ry 28b. Time y Year) Injury	Work	at ? ∕es 2 □ No	28d. Describe ho	ow injury occur	red	
Divi	- 0 - ·		4 Homicide determined	building, etc				28f. Location (St City or Town	n, State)		
	To the Hospital or within 24 hours aft To the Funeral Discompletely filled in	edicai	29a. Certifier 1 Certifying P. (Check only one)	hysician: To the best ominer: On the basis of and manner sta	examination and/or i	ath occurred at the tim nvestigation, in my op	e, date and place, a inion, death occurre	and due to the ca ed at the time, d	ause(s) and ma ate and place,	anner as state and due to th	ed. ne cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier			29c. License	number 38353	2	9d. Date signe  June 2		
	30		30. Name and address of person who  Rene Desmail	completed cause of de	eath (Item 23a) (Type			De C			
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	boards	SHOIL	V ~ Q	(113000	עווי ץ	, 01003

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		State of Maryland / Depar State of Maryland / Depart / D			2004 21231
Physic	ian	1. Decedent's Name (First, Middle, Last)  DOLLE TOV DANIE FR			Oay Year 3. Time of Death 0216 M
/Medi Exami			4b. City, Town, or Location of Death		c. County of Death
Funeral Director	Г	5. Social Security Number  6. Sex  1 M 2 D F  Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Nonth, Day, Yea July 2, 20	9. Birthplace (State or Foreign Country)  MARYLAND
D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local			10d. Inside City Limits
Maryl.	ctor	MARYLAND N/A BALTIN	MORE		1 ∑Yes 2 □ No
with the a or 28s	Director	10e. Street and Number	10f. Zip Code		Citizen of What Country?
death or 23	neral	102 N. L AKEWOOD AVE.  11. Marital Status  12. Was Decedent Ever in U.S. If Marital Status  13. Was Decedent Ever in U.S. If Marital Status	as Decedent of Hispanic Origin? (Speryes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - American Indian, Black, White, etc.
BAITIMOFE, MARYIBING Z1Z13-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avent. I'm Modical Examinat must be notified at any once.	by Funeral	1 5 Never Married 2 □ Married 1 □ Yes 2 ▼ No	Yes 2 No Specify:		Specify: WHITE
13-C	Completed	(Specify only highest grade completed) (Give killife. Do	nt's Usual Occupation ind of work done during most of workin O NOT use retired)		Kind of Business/Industry
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and 2 and 2 m 27 li		/ /	V.LAKEWOOD AV	E. BALT	O. MD. 2/224 Location - City or Town, State
Baltimore, Dermit. Pages 1 a Department of He- Important: If item any injury or othe once.		cemetery, crema	atory or other place)		
Baltin permit. P Departme Importan any injury		*4 □Donation 5 □Other (Specify) BAYVIEW C1  21. Signature of Funeral Service Licensee 22.	Name and Address of Facility / / 1	LY+ZFI	ALTIMORE CITY LER, INC. FUNERAL HOM
n refi		Catherine M. Jeelen 19 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter	OI EASTERN AVE	BALTIN	ORE, MO 2/23/
	ı			respiratory arrest,	Interval Between Onset and Death
Physician /Medical	ı	Immediate Cause (Final disease or condition resulting in death)  a.   Prematurity (Constitution of the cause	KTremei		11 hours
Examiner	_	Sequentially list aunditions b. Sep Si S			11 hours
uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Distress Sui	ndrome	e II hours
18760, cate be executed physicien and the burial-transit	I Exe	resulting in death) Last Due to (or a la consequence of):	,		
	edical	d	7755		
H.O. BOX to that the death certified by the attending detached for use as	by Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Ords, P.O. requires that the een signed by the hould be detached.	y Ph	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
COTOS  w requires been sign		none		1 🗆 Yes	2 XNo 3 ☐ Probably 4 ☐ Unknown
I KeC The law ete has b	Completed			24a. Was an autopsy performed?	
Of VITAL Physician: The this cartificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death		C Flores (Constant
Phy rthis	n: To	27. Manner of Death 28a. Date of Dury 28b. Time of	3 DOA 4 Nursing Hori	8d. Describe how inj	6 □Other (Specify) jury occurred
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DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the tu	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death one)  2 Medical Examiner: On the basis of examination and/or investance and manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	nd due to the cause( od at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier  Camen Cormbs, M.D.	29c. License number  RES - 000	7	Date signed (Month, Day, Year) 7 / 3 / 0 4
/		30. Name and address of person who completed cause of death (Item 23a) (Type, P	rint) Notce St. Bo	11:	md 21287
S	tate	31. Date filed (Month, Day, Year)  32. Ragistrar's Signature	Notice ST. 196	Himore,	1110 21201
Regis	trar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	arks		

ORIGINAL

			1- For Sta		artment of Health and M rtificate of Death	ental Hygiene
	Physici		1. Decedent's Name (First, Middle, Last)	maying		2. Date of Death Month Day Year  Month Day Year  M
	/Medi Examir		4a. Facility Name (If not institution, give street a	nd number)	4b. City, Town, or Location of Death	4c. County of Peath
ш			GOOD SAMARATAN HO	SPITAL	BALTIMORE	NA
	Funeral Director		5. Social Security Number 6. Sex 1 M 21	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)  JUNE 16, 1922  9. Birthplace (State or Foreign Country)  MD
	land ow		10a. State 10b. County	10c. City, Town or Lo	ocation	10d. Inside City Limits
	Mary First	5	MD BALTIMON	ze l	DUNDALK	1 Tyes 2 No
	h the	irec	10e. Street and Number		10f. Zip Code	10g. Citizen of What Country?
	238 C	a	7533 WESTFIEL	Q RD.	2122	U.S.A.
920	72 hours after deeth with the Maryland natural', or Items 23a or 28a-1 show disal Evantreer must be rediffed at	by Funeral Director	1 Never Married 2 Married 1 If Y	Yes 2 →No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes2 ☑ NoSpecify:	cify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
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Je,			20a. Method of Disposition	20b. Place of Dispo	sition (Name of D.	ate 20c. Location - City or Town, State
E	Page nent c ant: If ury or		*4 ☐ Burial 2 ☐ Cremation 3 ☐ Removal *4 ☐ Donation 5 ☐ Other (Specify)		2 centery 7/8	loy Balte Ms.
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signifure of Funeral Service Licensee		Name and Address of Facility  HARTIEU Miller - 5	TellA Funeral Home CHTD. D. Bolto MS 21234
			28a. Pary . Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do not enter	er the mode of dying, such as cardiac or	respiratory arrest, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Metastal	Mc Concono	matosil Onset and Death
	/Medical Examiner		resulting in death)	uê to (or as a consequence of):		
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8760,	icate be executed physician and s the burial-transit	edical	d			
89	rtifica ng ph	Med	IF FEMALE:			
P.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)	23d. Date of delivery  Month Day Year
Division of Vital Records, P	w requires that s been signed b should be deta	þ	Part II. Other significant conditions contribution	g to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
ecc	ne law re has be- ge 2 sho	Completed	Hyperten	ylon		24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
<u>~</u>		Som	21			performed? death?  1 Yes 2 No 1 Yes 2 No
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<del>_</del>	Physi this c	2	1 ☐ Yes 2 DNo Hospital:  27. Manner of Death 28a.	1 Inpatient 2 ER/Outpatient		e 5 Residence 6 Other (Specify)
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isi	Attending Physician: r death. ector: After this certifice by the funeral director, p	fica	2 Accident investigation 3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, stre		Bf. Location (Street and Number or Rural Route Number,
<u>S</u>	el or / s after al Dire ed in b	Certification;	4 Homicide determined 255.	building, etc. (Specify)	2.5	City or Town, State)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical (	2   Medical Examiner. On	To the best of my knowledge, death the basis of examination and/or inviting manner stated.	occurred at the time, date and place, ar estigation, in my opinion, death occurred	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	WW. GARS	29c. License number	29d. Date signed (Month, Day, Year)
	20		30. Name and address of parson who completes	Cause of death (Itam 22a) (Turns	Print)	7-4-2004
	.0		30. Name and address of person who completed 56 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	32 Registrar's Signature	sallmone.	MB 51534
	Sta Registr		JUL 0 7 2004	oz negistrar s signature	soli	

			1 - For State Registrar	State of Maryl	•	artment of F		, ,	jiene eg. No?	21233
	Physici /Medic		Decedent's Name (First, Middle, Las	Leo	Eibr	ner		2. Date of Dea Month	th Day Yes	
	Examin		4a. Facility Name (If not institution, give GOOA SUMAV  5. Social Security Number 6. Se	itan Hos	pital frs. last birthday	4b. City, Town, o	Location of Dea	ith	4c. County of D	eath
	Funeral Director			7. Age (m) ΣΝΜ 2□ F 72	Yrs. last birthday,	Months Days	Hours Mir			Birthplace (State or Foreign Country) Iaryland
	a-f show	ctor	10a. State 10b. County	imore 10c	. City, Town or L	ocation	Dundal	k		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	i Director	10e. Street and Number 5530 Force Road			10f. Zip Code	21222		Og. Citizen of What United S	,
36	72 hours after death with the Maryland natural; or Hams 23a or 28a-f show Jical Evand art must be troilled at	by Funeral	11. Marital Status  1	12. Was Decedent Ever i Armed Forces? 1♥ Yes 2⊕ No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Specify Yes or No- rto Rican, etc.)		merican Indian,
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Maryland	and 2 should be salth and Mental n 27 Is markad ier traumatic av		19a. Informant's Name/Relationship (7 Mr. Greg Eibner/			ng Address (Street Flintloc			, City or Town, State Maryland	
Baltimore,	Pages 1 and 3 nent of Health ant: If itam 27 ary or other tra		20a. Method of Disposition  1  Burial 2	Removal from State		osition (Name of matory or other place Service (			20c. Location - City	
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licens		ř	2. Name and Addre	ss of Facility Funeral		Dundalk,	Ińc. 21222
8760,	Incate be executed by Security Medical Examiner	edicai Examiner	23a. Part1. Enter the disease, or compands, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, flag later of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a conduct.  Due to (or as a conduct.)  Due to (or as a conduct.)	death. Do not en	ter the mode of dyin	ng, such as cardia	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
O. Box 68	ne death certif the attending thed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ If 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of Month	delivery Day Year
rds, P.	ires sign d be	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	inderlying cause giv	en in Part I.	23e. Did to	_	to the cause of death?  Probably 4 20nknown
of Vital Records,	The ate har page	Completed						24a. Was a autops perform	y prior	autopsy findings available o completion of cause of ? es 2 \( \text{No} \)
Vita	Physician: The his certificate	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3□ DOA Oth	00	eath (Check only on	e) ence 6 □Other (S	nacify)
	ding h. After fune	cation: T	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time o	of 28c. Injur Wor			ow injury occurred	boony
Division	in Site	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, st pecify)	reet, factory, office		28f. Location (Si City or Town	reet and Number or n, State)	Rural Route Number,
	To tha Hospital or At within 24 hours after or To tha Funaral Direct completely filled in by	edical	(Check only 2 Medical Exam	/sician: To the best of my iner: On the basis of examand manner stated.	knowledge, deat mination and/or in	vestigation, in my o	pinion, death occ	surred at the time, d	ate and place, and o	ue to the cause(s)
1	To t To t	Σ	29b. Signature and title of certifier			29c. Licens			9d. Date signed (Mo	
	7.11	III	30. Name and address of person who o	ompleted cause of death	(Item 23a) (Type,	Print)	7 179	10	Miyor,	2004 MD 21239
*	7   Sta	ite	Teve Sa Mun 31. Date filed (Month, Day, Year)	5, 50 32. Registrar's S	ignature	ch Kav	en Blva	1.13017	more,	MD 21239
-	Registr	ar	0 7 2004	Believe	6	Soul				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2004 **EVANS** JUNE GERTRUDE Α. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hartord Home Nursing Harre De Grace | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | August 20, | Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) 1 ☐ M 2 🕮 F 93 Maryland 220-12-1616 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 No Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 W. Main Street - Apartment 21817 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 XNo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Fuel Company Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Noah Smith Leona Landon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen E. Lurton (Daughter) 2907 Rolling Green Drive - Churchville, MD 21028 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐Donation 5 ☐ Other (Specify) Sunnyridge Memorial Park July 3, 2004 Crisfield, Maryland 22 Name and Address of Eacility Bradshaw & Sons Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
BradShaw & Sons Funeral Hom
Mary Beth BradShaw-Pruitt

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 306 W. Main Street - Crisfield, Maryland 21817 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) M DEMENTIA Due to (or as a consequence of): LZHEIMER'S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 □Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? DISK DIS. LUM BOSACRAL 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy Compression FRACTURE - L2 ormed2 2 No 1 ☐ Yes 2 ☐ No 1 Yes 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "naturel", or items 23a or 28a-f ehow the Medical Examiner must be notified at

al Hygiene.

s 1 and 2 of Health item 27 i

should be is marked

Pages

Maryland 21215-0036

Baltimore.

Box

P.0.

Records,

Vital

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Division

Direct

Completed by

use as the burial-transit and Completed by Physician/Medical Medical Certification: To Director: After this in by the funeral death. or A To the Hospitel
within 24 hours a
To the Funeret C
completely filled

25. Was case referred to medical examiner?

1 \( \sum \) Yes 2 \( \sum \) No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1. Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and Meyof certifier

29c. License number

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) S. GALVEZ, M.O.

S. UNION AVE. HAURE DE GRACE

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

M.D.

			For Stete Registrar	State of Maryla		artment o			d Menta	l Hygie			0100	) p.m
			Decedent's Name (First, Middle, La	st)						of Death	200	1.5	3. Time-of 19	bath
	Physicia /Medic		Gloria May	Fuller					Mor		Day 200	Year	9.05	PM
	Examin		4a. Facility Name (If not institution, give	re street and number)		4b. City, To	wn, or L	ocation of De	eath		4c. County	of Death		
			NERTH ARUN	DEL HOLP	TAL	Ci23	NE	SURIN		1 4	Anim-	3 F	FREND	EL
	Funeral		5. Social Security Number 6. 5		rs. last birthday) 70 Yrs.	If Under 1 Months [	Year Days	If Under 24 h	Irs. 8. Date	of Birth oth, Day, Ye	ar)	9. Birthp	place (State or F	Foreign
	Director		212-30-3535 Usual Residence of Decedent		72 Yrs.	L			May	18	1932		MD	
	land ow		10a. State 10b. County	10c.	City, Town or Lo	cation							Od. Inside City	Limits
4	Mary 1sh	to	Maryland Anne A	rundel			Pa	sadena					1 [ Yes 2	. No
7	r 28e	Director	10e. Street and Number			10f. Zip C				10g.	Citizen of V	Vhat Cou	ntry?	
SLORIA	1 with	ai D	8052 Maywood A	venue			21	122				USA	1	
36	ems ems	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deceder f Yes, specify	nt of His	panic Origin?	(Specify Yes	s or No-		e - Americ	an Indian,	
0	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give		1 ☐ Yes 20		Specify:		,	Specify	L III	ite	
177.0	hour ture!	d b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:	100 D	d d. 11 14				1				
75	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show the Medical Exeminar must be institled at	ojete	(Specify only highest gr	ade completed)	(Give	dent's Usual ( kind of work of DO NOT use	occupati done du retired)	ring most of	working	166	. Kind of Bu	siness/in	dustry	
125	yiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Homema					Ноц	useho	old	
T B	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle, Last	)			1	8. Mother's h	Name (First, i	Middle, Maid				
/lai	uld b Ments arked	ToE	Lester So	chafer	_			Cath	erine	Wo	olf			
lan	2 sho and is me		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (S	Street an	d Number or	Rural Route	Number, Ci	y or Town,	State, Zip	Code)	
≥,	and ealth m 27 her tr		Joseph R. Fuller	(spouse)		2 Maywo		<u>Avenue</u>						
o o	ges 1 t of H If ite or otl		20a. Method of Disposition 1 Ø Burial 2 ☐ Cremation 3 ☐	Bemoval from State	. Place of Dispo cemetery, cren	natory or other	er place)	1 (11)	Ty 09		Location -	,		
ドルルER Baltimore, Maryland 21215-0036	t. Pa rtmen rtent; rjury		'4 □Donation 5 □ Other (Special		len Have			У ¦	2004	Gle	en Bur	'nie,	Maryla	ind
Bal	permit. Pages 1 and 2 should be liled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show eny Injury or other treumatic event, the Medical Examinar must be institled at QRES.		21. Signiture of Funeral Service Like	il /	22	2. Name and A			Sta oad, P				Home, F	٠.A.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	eath. Do not ent						10 4 112		Approximate Interval Betwe	en
	Physician		Immediate Cause (Final disease or condition	CREEZED		CulAt	_	A	DEN				Onset and Dea	
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):									
11	LAdilline	_	Sequentially list conditions,	b. DIATERS		石町	CORR							
Dr	ecuted and transit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons		CUI	53.5	25	nena	P.4 :	7.5=10	-7		
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cons		W.C.	142	_(00			(35:-	)=		
8760	e be /sicia	dicail	· ·	d										
9	tificate ig phys as the	ledi												
XO	th cer endin	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1□Live birth 2□Fe		Ectopic preg	nancy				23d. Date			
Э. Е	e dea the att	by Physician/Me	in the past 12 months? 1 Yes 2 No	4□Pregnant at time of		Other (spec					Mor	ith	Day Yea	ar
P.0	d by testach	Phy	9 ☐ Unknown  Part II. Other significant conditions	Contributing to double but not s	coulting in the	-doching on		in Don't	220	Did tabasa				450
Division of Vital Records, P.O. Box	The faw requires that the death certificate has been signed by the attending page 2 should be detached for use as	d by	Fattii. Other significant conditions	CONTRIBUTING TO GOZIN DIR NOT	esuling in the u	idenying caus	se given	in Part I.	236	1 ☐ Yes		3 ☐ Prob	ably 4 Dunk	
Ö	v requ been shoul	etec							-					
Rec	ne fav n has ge 2	Completed							- Z4a	. Was an autopsy performed	24b. V	vere auto rior to cor eath?	psy findings ava npletion of caus	se of
a	n: Th	e Co	25. Was case referred to medical							Yes 2 🗸		Yes	2 No	
Ξ	s cert	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA	Other		Death <i>(Check</i> g Home 5			. 10:		
ō	g Phy er this eral c	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)			i. Injury a Work?			scribe how in			0	
io	Attending Physicien: r death. sctor: After this certifica	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	n	Injury	М		s 2 🗆 No						
ivis	or Atterdenter de Directo	Certification:	3 Suicide 6 Could not be determined		home, farm, str	eet, factory, o	office		28f. Loca City	ation (Street or Town, St	and Numbe	er or Rura	Route Number	r,
0	urs af													
	To the Hospitel or Attending Physicien: The favinin 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier 1	nysicien: To the best of my k miner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at estigation, in	the time my opir	, date and pla nion, death or	ace, and due ocurred at the	to the cause time, date a	(s) and mar and place, a	ner as st nd due to	ated. the cause(s)	
	To the comp	Σ	29b. Signature and title of certifier			29c. L	icense r	number		29d	ate signed	(Month,	Day, Year)	
			150170	MU		(0)	42	ital		0	uly	0 4	m00 et	
	10		30. Name and address of person who	completed cause of death (It	tem 23a) (Type,	Print)	re	Cole	n 13;	Isnu	2 1/	N	2106	i
	Sta Registr		31. Date filed (Month Day, Xear)00	32. Registrar's Sig	nature									

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	•	1 - For State of Marylar Registrer		artment of Heartificate of De			ene s. No.2	21236		
Physic		Decedent's Name (First, Middle, Last)  Joseph Frank Faimann				2. Date of Death Month July 4	Day 2 Year	5. Your		
/Medi Exami		4a. Facility Name (If not institution, give street and number)  Mercy Hospital		4b. City, Town, or Lo Baltimo	ore	J	4c. County of Deatl	1		
Funeral Director		215 05 7544 XXM 2□F	94 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 05/13/1		nplece (State or Foreign untry) ryland		
Maryland f show	tor	,	ity, Town or Lo					10d. Inside City Limits 1X Yes 2 ☐ No		
with the 3a or 28e-	Funeral Director	10e. Street and Number 712 N. Madeira St.		10f. Zip Code 212	205	10	g. Citizen of What Co USA	untry?		
Ind 21215-0036  be filed within 72 hours after death with the Maryland ttal Hygiene.  d other then "natural", or Items 23s or 28e-f show event, the Madical Examinar must be natilised at	by	11. Marital Status  1 ★ Never Married 2 ← Married  3 ★ Widowed 4 ← Divorced  12. Was Decedent Ever in Amed Forces?  1 ★ Yes Cive Yes Cive Year or Dates:	ĺ	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No	eanic Origin? (Spi Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:			
Maryland 21215-0036 at 2 should be filed within 72 hours all the and Mental Hygiene. 77 is marked other than "natural", or treumatic event, the Madical Exuts.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  7  College (1-4or 5+)	(Give	dent's Usual Occupation in the desired of work done dure DO NOT use retired)	on ring most of work	ing	6b. Kind of Business/ Milton Art			
ryland 2121 should be filed within ad Mental Hygiene. marked other then matic event, the Ma	To Be Co	17. Father's Name (First, Middle, Last) Frank Faimann			18. Mother's Name (First, Middle, Maiden Sumame)  Elizabeth UNK  and Number or Rural Route Number, City or Town, State, Zip Code)					
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		Burial 2 Cremation 3 Hemoval from State	20 S. Place of Disport cometery, cres 1y Rede		5t. 1200	Sun Life 2004 Bach/Rosed	e Bld <sub>E</sub> . Ba Oc. Location - City or altimore M ale Funera	lto., MD 212 Town, State D. 1 Home		
Box 68760, Sath certificate be executed The sath certificate be executed attending physician and for use as the burial-transit		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last  Due to (or as a consecutive consecution).	Farequence of):	rasc Oure emia				days		
. 5 .5	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year		
cords, P.O. w requires that the been signed by the	کر	Part II. Other significant conditions contributing to death but not re	esulting in the t	underlying cause given	in Part I.		acco use contribute to	4		
Vital Records, sician: The law requires the certificate has been signed irrector, page 2 should be of	Completed	O				24a. Was an autopsy performed?  1 Yes 2 No 1 Yes 2 No				
Phy Phy ral d	ion: To Be	27. Manner of Death 1 Anatural 5 ☐ Pending (Month, Day Year)	ER/Outpatie	of 28c. Injury a Work?	4 Nursing Ho		lesidence 6 Other (Specify) be how injury occurred			
Division  or Attending safter death. I Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - Al building, etc. (Spe	thome, farm, s			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
he Hospitu in 24 hours he Funere pletely fille	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examinand manner stated.	knowledge, dea ination and/or ii	nvestigation, in my opi	nion, death occur	red at the time, da	ate and place, and due	e to the cause(s)		
To t To t Commo	2	29b. Signature and title of certifier  Sydum, N. D.		29c. License	6050	29	July 4	1200 4		
Ý	state	30. Name an address of person who completed cause of death (I	St. D	and place	a	Baltin	more, M	0 21202		
Regi		0 7 2004	10 6	land .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death dent's Name (First, Middle, Last) **Physician** /Medical give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, Examiner timore Date of Birth (Month, Day, Age (In yrs. last birthday) Birthplace (State or Foreign 6 Sex **Funeral** Months Hours 1 MM 2 □ F 5 Director DOM I Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-1 show of Health and Mental Hygiene. Item 23e or 28e-1 show then 27 is marked other then "natural", or items 23e or 28e-1 show other traumatic event, the Medical Examiner Tatal be netitied at 1 ☐ Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) #Jary (0-12) ther's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 19a. Informant Rural Route Number, City or Town, 19b. Mailing Address (Street and Nu Baltimore, 20b. Place of Disposition (Name of Method of Disposition 5 = 5 1 Burial 2 Cremation 3 Removal from State Department o Importent: If eny injury or 4 ☐ Donation

21. Sig proper of F 5 Other (Specify) e of Funeral Service L M 1399 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Hebatoc Month 2 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Il-transit The taw requires that the death certificate be executed Due to (or as a consequence of): the attending physician a thed for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 X No 3 Probably 4 Unknown 1 Tyes page 2 should Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No After this certificate has 1 Yes 2 0 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 4 Nursing Home 5 Residence 6 □Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA P 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. 28b. Time of Injury at Work? Certification: 5 Pending investigation 1 Natural 2 No М 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

s Signature

	,		For	State of M	aryland						000		
			1 - State Registrar	1		Cer	tificate of	Death		2. Date of Deat	g. Nø.	Lj	21238
	Physici	an	1. Decedent's Name (First, Middle		ızman					Month	Day	Year 2004	11:50 A M
	/Medic Examin		Joshua 4a. Fecility Name (If not institution		<u>uzman</u>		4b. City, Town, o	r Location	of Death	July	4c. County		11.50
	LXamii	-	THO JOHNS	HOPKINS	Hoso	ital	Balti	mor	e (	-it-v		N/A	
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. lasi	t birthday) Yrs.	Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth Month, Day, July 05	Year)	9. Birthpl Coun	ace (Stete or Foreign try)
	Director		N/A Usual Residence of Decedent	154		Yrs.		1	20_	July 05	2004		<u>MD</u>
	/land		10a. State 10b. County		10c. City, T	own or Lo	cation					10	Od. Inside City Limits
	a-f sh	ţ	Maryland Anne	Arundel			Р	asade	na				1 ☐ Yes 2 💢 No
	or 28	Director	10e. Street and Number				10f. Zip Code	04064		10	0g. Citizen of W		try?
	72 hours after death with the Maryland 'naturel', or Iteme 23a or 28a-f show Jibal Exacifor must be natilled at		483 Glen Mar		5	40.1	_1	21061	-:-2 (0	of Venes No		SA - America	an Indian
	item Item	Funeral	11. Marital Status 1	12. Was Decedent Armed Forces? ied 1 ☐ Yes 2 🔀	?	13. V	Vas Decedent of F Yes, specify Cuba	an, Mexicar	n, Puerto F	Rican, etc.)		k, White, e	
920	urs af el', or	Ď	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2X No	Specify:			Specify:	W	nite
2-0	72 ho	Completed	15. Deceden	t's Education	1	(Give	ent's Usual Occup	durina mos	t of workin	ng .	16b. Kind of Bu	siness/Ind	lustry
2	within ene. than "	mpie	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT use retired N/A	d)			N	I/A	
7	filed v Hygie other t		N/A  17. Father's Name (First, Middle,	Last)			IV/ A	18. Moth	er's Name	(First, Middle, N			
Maryland 21215-0036		To Be	Michael	Guzman					salyn	_	ordon		
ary	2 should be and Mental le marked eumatic ev	-	19a. Informant's Name/Relations	, , , ,		19b. Mailin	g Address (Street	and Numb	er or Rural	Route Number,	City or Town, S	State, Zip	Code)
	and 2 lealth a m 27 ls		Michael Guzman	(father)	1		Glen Mar	Circ	14	-			
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 Removal from State	cem	етегу, степ	sition (Name of natory or other place		Julv	06	20c. Location - (		
ţ	t. Partmen		* 4 ☐ Donation 5 ☐ Other (S		Metr		matory I . Name and Addre			, ,	altimor		Home, P.A.
Bal	permit. Page Department Importent: If any injury or once.		21. Signature of Edmeral Serve	Zul A		22	3111 Mou				-		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	d the death.	Do not ente	or the mode of dyir	ng, such as	cardiac or	r respiratory arre	est,	211	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	E.V.	- 10 m	10	./ )	na	1	ritu			Onset and Death
	/Medical		resulting in death)	Due to (or as	s a consequer	nce of):	1121	1 100		7			Move
	Examiner		Sequentially list conditions, b										
	ped sit	nine											
,	al-trai	Examin	that initiated events resulting in death) Last	c Due to (or as	s a consequer	nce of):							
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai		d									
9	ing ph	Med	IF FEMALE:										
Вох	leath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal de	ath 3	Ectopic pregnancy	у			23d. Date Mon	e of delive oth	ry Day Year
0	at the de by the a tached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of deat	n s∟	Other (specify) _						
٦.	g p	by Ph	Part II. Other significant condition	ns contributing to death	but not resulti	ng in the ur	nderlying cause giv	en in Part I		23e. Did tob	acco use contri	ibute to th	e cause of death?
rds	quires an signe	ed b								1 ☐ Ye	s 2 No	3 Probe	ably 4 Unknown
Record	law requas been 2 shoul	Completed								24a. Was ar	n 24b. W	√ere autor	osy findings available
E B		Соп								perform	ned? d	eath?	2 No
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medica examiner?	Hassital: M			Ott	or:		(Check only on			
of		. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inj (Month, D		VOutpatien 3b. Time of	t 3 DOA 28c. Injui	4 🗀 🖂		ne 5 Reside 28d. Describe ho			)
ion	Attending For death.  sector: After by the funeral	atior	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	9	ay Year)	Injury		rk? ∣Yes 2 🗌	No				
Division	I or Attendi after death. Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Place of in	njury - At home etc. (Specify)	e, farm, str	eet, factory, office		2	8f. Location (Sti City or Town		or Rural	Route Number,
۵	ital or irs afte rel Dir												
	To the Hospital within 24 hours a To the Funerel I completely filled	Medical		ng Physicien: To the bes Exeminer: On the basis and manner s	of examination								
	To the within to the To the comple	Med	29b. Signature and title of certifie				29c. Licens	se number		29	9d. Date signed	(Month, [	Day, Year)
	~ > P 0		> All- 1	4. lot			RE	5-0	00		7161	104	+
			30. Name and address of person	who completed cause of	death (Item 2	3a) (Type,	Print)						
			ALICE CH	UNG COO	TAUCC	2	600 N	. WOL	FE S	T, BA	17 MULE	Mi	21287
	Sta Regist		31. Date filed (Month, Day, Year)	32. Regis	inar a Signatur	rette )							
				A STATE OF THE STA		- TANKS -							

	-	For Stete Registrer	State of M		artment of		and Mental Hyg	giene	21230		
Physicia /Medica		1. Decedent's Name (First, Middle, MARTIN L. GI					2. Date of Dea Month July	1-01	3. Time of Death 7:10 a M		
Examine	er	4a. Facility Name (If not institution, Greater Baltimor	e Medical	Center		n, or Location or SON		Baltimor	4c. County of Death Baltimore		
Funeral Director		5. Social Security Number 168-14-0421  Usual Residence of Decedent	5. Sex 7. A 11XIM 2□ F	ge (In yrs. last birthday, 86 Yrs.	Months Day		Min. 8. Date of Birth (Month, Day 10/5/19		thplace (State or Foreign puritry)		
h the Maryland r 28a-f ehow	ctor	MD 10b. County Harfo	ord	10c. City, Town or L					10d. Inside City Limits 11 Yes 2 □ No		
ath with th	Funeral Director	10e. Street and Number 104 Eastern Av	enue		10f. Zip Cod 21	014		10g. Citizen of What Co USA	ountry?		
d 21215-0036  filed within 72 hours after death with the Maryland Hygiene.  than "natural", or Items 23a or 28a-f ehow ent, the Mcdical Examiner must be notified at	۵	11. Marital Status  1X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 X es 2 If Yes, Give Year or Dates:	? No WWTT	Was Decedent of If Yes, specify C		gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Ame Black, Whit Specify: Whi	e, etc.		
Maryland 21215-0036 to 2 should be filed within 72 hours aff the and Mental Hygiene. 77 Is marked other then "natural", or traumatic event, the Medical Exemitations.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12		(Give	dent's Usual Oc kind of work do DO NOT use rei Realtor	ne during most	of working	16b. Kind of Business, Real Es	ŕ		
E dala	To Be C	17. Father's Name (First, Middle, La Charles A. Gla			-		r's Name <i>(First, Middl</i> e, hala McAll				
		19a. Informant's Name/Relationshi Susan G. Miller					ror Rural Route Numbe Cawn Grove,		Zip Code)		
Pa Pa Int.		20a. Method of Disposition 1   Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spe		20b. Place of Dispondence St. Mary's	matory`or other	place)	7/6/2004	20c. Location - City or Pylesville			
Baltim permit. Pag Department Important: any injury once.		21. Sign of Funeral Service Li	- Vare		2. Name and Ad <b>arkins Fu</b>		me,Inc.,600 Ma	ain St.,Delta,	PA 17314		
876(	hysician/Medical Exar	Anock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	s a consequence of):  a consequence of):  a consequence of):	y drat	mba	tron A	CRF	Interval Between Onset and Death		
P.O. Box 6i		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregna □ Other (specify)			23d. Date of deli Month	ivery Day Year		
aw require		Part II. Other significant condition	s contributing to death	but not resulting in the u	inderlying cause	given in Part f.	1 ☐ Y 24a. Was a autop perfor	an 24b. Were au prior to commend?			
of Vital Re	To Be	25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	Hospital: 1 Inpat	ient 2 ☐ ER/Outpatie	nt 3 DOA	Other	of Death (Check only or		cify)		
DIVISION OF  To the Hospital or Attanding Physical Description of Attanding Physical Director: After this completely filled in by the funeral discontinuated of the funeral discontinuation of the funeral discontinuatio	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could no		ury a <i>y</i> Yea <i>r</i> ) 28b. Time o Injury		njury at Work? I □ Yes 2 □ N	No	now injury occurred			
DIVIS		4 Homicide determin	building,	njury - At home, farm, st etc. (Specify)			City or Tow				
Division of the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical	(Check only 2 Medical E		of examination and/or in	nvestigation, in m	ny opinion, deat	d place, and due to the o		to the cause(s)		
T V S C C C C C C C C C C C C C C C C C C	2	29b. Signature and title of certifier	5LA	V M	.) /	ense number	42	770	) 4		
19		30. Name and address of person w	ture un)	8800 L	Print)	- B1	ed lut	ville 212	.34		
Stat Registra		31. Date filed (Month, Day, Year) JUL 0 7 2004	32. Regis	trar's Signature	souther						

unpend item#23a,27,28a-f,PER ME,G833,7/21/04eg Tyrone J. Grasso Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 4273DOS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Tyrone J. Grasso June 30, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 320 S. Kresson Street Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 6, 1963 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F 212-86-0610 Yrs. Director 40 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show Baltimore Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8006 Gough Street ftems 23a 21224 USA by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 9 Baltimore, Marvland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 XDivorced "natural". Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Areo Roofing Co. Elementary/Secondary (0-12) College (1-4or 5+) Carpenter 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosario C. Grasso Dolores Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun <u>once.</u> Shawn Grasso / brother 8006 Gough Street Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OakLawnCemetery 7/6/04 Baltimore MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Liet only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Narcotic (Heroin) Intoxication Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Box 68760 pe

attending physician for use as the burial Physician/Medical þ Completed Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 2

1 X Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

2 🗌 No

P.O.

Division of Vital Records,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 4☐Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of

2□ No

Day

Year

at scene

1133 a'

1 ☐ Yes 2 🔀 No

24a. Was an Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 5 Pending investigation fam 6/30/04 fourd 11:26a

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6X Other (Specify) 28d. Describe how injury occurred

2 No

unknown 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found: in woods

28f. Location (Street and Number or Rural Route Number, City or Town, State) (rear of) 320 S. Kresson St., Balt, City

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature a

6 Could not be determined

29c. License number

296. Date signed (Month, Day, Year)

30. Name and address of person who comple

OCME

July 1, 2004

HOG

ase of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) JUL 0 7 2004 32. Registrar's Signature

State

Registrar

To the Hospital within 24 hours a To the Funeral C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #20b PER FR G833 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ROBERT GARDNER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Neme (If not institution, give street and number) Examiner Baltimore 0 Genera N/A spital arvland If Under 1 Year | If Under 24 Hrs. Birth Day, Yea 20, 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of (Month, 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours **№** M 2 🗆 F 67 Yrs. 213 32 3528 1936 MARYLAND Director Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or Itama 23a or 28a-f show other traumatic event, the Medical Examinar must be nixtified at 1⊠Yes 2□No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1815 ASHBURTON STREET 21216 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12th SECURITY GUARD BOXER PROPERTIES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be ntal WILLIAM GARDNER JR. JEANETTE KEENE ဂ Men 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and Important: If item 27 eny injury or other tr 1650 NORMAL AVENUE BALTIMORE, MARYLAND 21213 DELORES B. CURBEAM (SISTER) Baltimore, 20b. Alace of Disposition (Name of Control o Date 20a. Method of Disposition 20c. Location - City or Town, State Department of 1 Burial 2 □ Cremation 3 □ Removal from \$tate GARRISON FOREST CEM JULY 13, 2004 BALTO, MARYLAND 4. ☐ Donation 5 ☐ Other (Specify) 21 Squature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 23a. Pert1. Enter the disease, or complications that caused the dilath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1412 E. PRESTON STREET BALTIMORE, MARYLAND 21213 Approximate Interval Between Onset and Death ythmia Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** ocardia Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner osclerofic Cardiovaclar the attending physicien and ned for use as the burial-transit Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. | 1 ☐ Yes 2 ☐ No. detached 9 Unknown 9 Unknown signed by d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 3 Probably 4 Unknown 1 □ Yes 2 □ No Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate 2 No 1 ☐ Yes of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Dispatient 2 ANO 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manher of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hoepitel or Attending I within 24 hours after death.
To the Funerel Director: After Division 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Portifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29c. License numbe 29d. Date signed (Month, Day, Year) Edwards Wireles-Carolens Jup 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ire

DHMH 17 Rev 1/2001

State Registrar Edi

Jardo

07 2004

31. Date filed (Month, Day, Year)

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**ORIGINAL** 

25

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First Middle Last) Year **Physician** July 4, 2004 6:45 AM Ellen Elizabeth George . /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2以F 81 Yrs. 214-52-2665 **Director** July 28, 1922 Georgia Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "neturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 1X Yes 2 □ No Maryland | Montgomery <u>Rockville</u> Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20851 1003 Scott Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If item 27 Is marked other the any injury or other treumetic event, In. 10.00. Administrative Assistant Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis David Silas Elizabeth Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Palmer Drive, Rome, Georgia 30165 to of Disposition (Name of Date 20c. Location Francis E. George/Son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Mont gome ry July 6, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematoriúm, Inc. ' 4 ☐ Donation 5 ☐ Other (Specify) 2004 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia **Physician** Unknows /Medical Due to (or as a consequence of): **Examiner** Cerebral Infarction Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed? Yes 22 No 1 ☐ Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No this funeral 28c. Injury at Work? Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Matural Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) uly 4, 2004 restintarker House MS D0059871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cristin Parker Howe mo Center Drive Rocieville, Maryland 9901 Medical 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUL 0 7 2004

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Day Year Month **Physician** 3:53 PM GIRSON RUBY 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Johns Hopkins Bayview Months Days Hours Min. 0 773 77 1933 0 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Tennessee 1 M 2 F 73 214-38-3117 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show other treumatic event, the Madical Examinar must be notified at 1 Yes 2 □ No N/A Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21231 or Items 23a 32 N. Chester Street Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. Ither than "natural", or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Assembly Line 3 permit. Pages 1 and 2 should be filed Department of Health end Mental Hyglic Important: If Item 27 is marked other i any Injury or other treumatic event 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Murray Thomas King ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Force - Daughter 32 N. Chester Street Baltimore, Maryland 20c. Location · City or Town, State 21231 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 07/07/2004 Baltimore, Maryland Oaklawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Series Licen Bavidad JdressWeber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** HYPERCARBIA disease or condition resulting in death) /Medical Due to (or as a consequence of) POVENTICATION SYNOROME Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner NTRACRANIAL HEMERRHAGE 18 MONTHS burial-transit 08 HISTORY that initiated events resulting in death) Last and certificate be exec Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the ettending physicien Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year 5 in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ል 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After To the Hospitel or Attending I within 24 hours efter death. To the Funerel Director: After 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 - Homicide within 24 hours e To the Funerel E Medicai 1 Secritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified accuracy M.D r 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE STREET; NORTH WOLFE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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			For State	State of Ma	ıryland	•			ientai Hy	/giene	001	01015
			Registrar			Certifica	ate of De	atn		Reg. No	UUL	21245
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	Examin	er	4a. Facility Name (If not institution, give		pita		ity, Town, or Loca Baltin	ore		NI	ounty of Death	
4	Funeral Director			Sex 7. Age	(In yrs. la	ot birthday) If Un Monti		Jnder 24 Hrs. ours Min.	8. Date of B Month, D	rth ay. Year 2 192	n hou	place (State or Foreign ntry)
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MM0/10	after or Ite	ρ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:	/		scedent of Hispan specify Cuban, M s 2 No Sp	nic Origin? (Spe exican, Puerto pecify:	ecity Yes or N Rican, etc.)		Race - Ameri Black, White, Decify: B	
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	s 1 and f Health item 27 other to		20a. Method of Disposition		20b. Pla	ice of Disposition (	Name of		Date	20c. Local	tion - City or T	own, State
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Balt	permit. Depart Import any inj		21. Signature & Funeral Service Lice	ensat /		GBM	and Andress of		in Fredi	iltonf	Pass Ra	21229 16, mp
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	Pnysician /Medical		disease condition resulting in death)	a. Due to (or as	a conseque		al d	allu	re		-	721
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P.O. Box 68	or Attending Physicien: The law requires that the death certificate is the death. Director: After this certificate has been signed by the attending physi in by the funeral director, page 2 should be detached for use as the I	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal	death 3⊡Ectopi	c pregnancy (specify)			230	d. Date of deliv	rery Day Year
	uires that signed b	þ	Part II. Other significent conditions	contributing to death b	ut not resul	ting in the underlyin	ng cause given in	Part I.		tobacco use  Yes 2□1		the cause of death? bably 4 @Unknown
Oivision of Vital Records,	e law requ has been ge 2 shou⊌	Completed							24e. Wa	s an	24b. Were auto	opsy findings available ompletion of cause of
<u>a</u>	: The cate ha	Com							per 1 ☐ Yes	2 No	death? 1 ☐ Yes	
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	(5)		30. Name and address of person who CHARU MEHT	o completed cause of d	eath (Item	23a) (Type, Print)	,000	brank	001	- in	- M3	791774
	Sta	ite.	31. Date filed (Month, Day, Year)	32, Registr	ar's Signatu	ure cho	000 101	reet,	150017	irnor	2 / (	. 01230
	Regist		1111 0 17 20	na Par	le	house						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 1:50 Am. Jul 4, 2004 Edgar Holeman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore** 815 W Saratoga Street Apt #6 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☑ M 2 ☐ F Months Days Hours Min Yrs Sep 17, 1924 Virginia 230-20-3016 79 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Baltimore N/A Directo Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö U.S.A. 21201 815 W Saratoga Street Apt #6 238 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1946 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc within 72 hours after 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 ò 1943 1 ☐ Yes 2 🗓 No Specify Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced 1946 "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Hutzler Co. Elementary/Secondary (0-12) College (1-4or 5+) Porter 12 should be filed w h and Mental Hygier 7 is marked other ti 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nannie Holeman Willie Holeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traum 815 W Saratoga Street Apt #6 Baltimore, Maryland 21201 Gloria Holeman Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/08/04 Crownsville . Md. Crownville Veterians Cem ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervat Between Onset and Death Immediate Cause (Final **Physician** Me tac Ta disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burlal-transit and Due to (or as a consequence of): ed by the attending physician detached for use as the burlal 68760 certificate be Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown cate has been signed by a page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes Wood 24a. Was an autopsy certificate 1 ☐ Yes 2/2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28b. Time of Injury Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and titl

31. Date filed (Month, Day, Year)

JUL 07 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

the

Johns

32. Registrar's Signature

29c. License number

RF(-000

phins Hospital

29d. Date signed (Month, Day, Year)

401 N. Broadwan

unpend item#23a,27,28a-f,PER ME,C833,7/21/04eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Gerald Hanson 04-04278 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar R.T Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2004 June 30, **Physician** 0830 P. M Gerald Hanson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula Regional Medical Center Wicomico County Salisbury If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec 25, 1958 6. Sex Funeral Months Min 1 MM 2□ F Days Hours 45 Yrs. Director 215-72-3652 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County itam 27 is markad othar than "natural", or itams 23s or 28a-f show othar traumatic evant, the Medical Examinar must be notified at 1 Yes 2 No Director Fruitland MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21826 United States 200 Sandcastle Blvd Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. JYes 2 No 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Yes, Give ò If Yes, Give Year or Dates: 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Building nd Mental Hygiene. markad othar than Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental Is ant: If itam 27 is markad of Robert Lee Hanson Gleema Zeli Lyall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Cassell/Sister 10012 Orchard Road, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State Jul 6 permit. Page Department of Important: If any injury or once. Beltsville, MD ¹ 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 2004 Funeral Service Licensee 22. Name and Address of Facility 21. Signalu 1100986 Cremation and Funeral Alternatives 8/1/ Green Pastures Drive Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Narcotic Intoxication Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 ☐ No 1 Yes 2 🗆 No 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XXYes 2 □ No funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 6/30/04 unknown 1 ☐ Yes 2 📉 No unknown 2 Accident after death Director: 6 X Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide building, etc. (Specify)

residence

Dividing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours a 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature apti title OCME July 1, 2004 cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 30. Name and address of person who com lete.

State Registrar

DHMH 17 Rev 1/2001

. Date filed (Month, Day, Year)

5-17.

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32. Registrar's Signature

Spake

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ector		5. Social Security Number 6. Sex		e (In yrs. last birthda	/) If Under	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da		g, Birth	nplace (Stete or Foreig
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or must be	Director	Maryland   Baltimor	<u> </u>	Dundar.		Code				10g. Citize	on of What Co	untry?
Pr Dist	٥	692 Wise Ave.				L222					ed Stat	•
276	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S. 13	. Was Dece	dent of H	lispanic Ori	igin? (Sp	ecify Yes or No	p- 14	. Race - Ame	
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mat	F	19a. Informant's Name/Relationship (Type	pe, Print)	19b. Ma	ling Address	s (Street	and Numbe	er or Rur	al Route Numb	er, City or T	Town, State, Z	ip Code)
or other traumatic event, the Mar		Teresa K. Purbaugh	(daught	er) 692	Wise	Ave.	Dui	ndall	k, Mary	land 2	21222	
othe		20a. Method of Disposition		20b. Place of Discometery, cr	position (Na	me of other plac	(e)	1	Date	20c. Loca	tion - City or	Fown, State
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2010		Part II. Other significent conditions con	tributing to death b	out not resulting in the	underlying o	cause giv	en in Part I		23e. Did 1	obacco use	contribute to	the cause of death?
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should	Completed	Chronic R	00001	in Sult	icia	2	C		24a. Was	an :	24b. Were au	opsy findings availa
page 2	mc	CHIVOTIC II	CMAI	113900	· CLE	-N)	y			psy prmed?	prior to c death?	ompletion of cause (
or, p	ပို	25. Was case referred to medical					26 Piace	of Deat	1 ☐ Yes	2.2 No	1 🗆 Yes	2 No
	O B	examiner?	lospital:	ent 2 ER/Outpati	ent 3 🗆 Do	Oth Oth	or		me 5 Resi	91	Manuel Inc.	- H-c-
70	Ë	27. Manner of Death	28a. Date of Inju (Month, Da	ıry 28b. Time		28c. Injur Wor	, ,		28d. Describe		occurred	" TOSPIC
completely litted in by the funer	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Inontal)	y roary mary	М		Yes 2	No				
5	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj	ury - At home, farm, s	street, factor	y, office			28f. Location ( City or To	Street and I	Number or Ru	ral Route Number,
3	Certification:			,,								
tion i	edical	29a. Certifier  (Check only one)  2 Medical Exami	sician: To the best ner: On the basis of and manner st	of my knowledge, dead examination and/or	ath occurred investigation	at the tire, in my o	me, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) ar date and pi	nd manner as lace, and due	stated. to the cause(s)
2	Med	29b. Signature and title of certifier	and manner st	ated.	29	c. Licens	e number			29d. Date s	signed (Month	Dev. Year)
			las					7		111	0/20	201
		30. Name and address of person while co	100	death (Item 23a) (Typ	D. C.	24	50°	1	- ved r	0/1	0/00	104

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 10:30PM 5+4 Howells Jenkin 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Franklin Square Hospital Center Rose dale der 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F Months Hours Min. 76 Usual Residence of Decedent Director 10c. City, Town or Location 10b. County 10d, Inside City Limits 10a State If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic avant, the Medical Exemples must be notified at 1 Yes 2 □ No Directo MD BALTI MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 5906 USA HVE by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: white Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore, Maryland 2121 College (1-4or 5+) Elementary/Secondary (0-12) Auto Dealership 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be t and Mental I Howell HImeda retterhott 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Greenhill Avr. L perrit. Pages 1 and 2 Department of Health at Impartant: If item 27 Is any injury or other trau 5906 BALTIMOLE MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State EVANSFUNERALCHAPFL- 17-10-04 1 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, MI) 22. Name and Address of Facility 7. Timonium, mD 21093 21. Signature of Funeral Service PEACEFUL ALTERNATIVES FUNGRAL OCKEMATION OTH 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Pnysician week /Medical Examiner Meumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of, Examiner burial-transit Due to (or a a consequence of): the attending physician Box 68760 arge B Cell Lymphome Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) P.0. detached 9☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, upus Erythematosu 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed Colon Concer 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has autopsy Myocardial Infarction 25. Was case referred medical examiner? 1 ☐ Yes Division of Vital 26. Place of Death (Check only one) 2**X**No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury filled in by the funeral 27. Manner of Death ate of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation 2 🗌 No death. after death Director: 6 Could not be 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funaral Completely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Drive, Baltimore, MD. 21237 H. Htay 32. Pegistrar's Signature State 2004 Registrar

			For State Registrar	State of	Maryland /		artment of rtificate of		d Mental Hy	giene Reg. No	711111	21250
	· ·		Decedent's Name (First, Middle, L.)	ast)					2. Date of De	eath De	v Year	3. Time of Death
	Physicia /Medic		Amelia	V.	Ţ-	lader			June 2	28, 2	2004	8:45 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, g 725 Crucible C	ve street and num ourt	ber)			or Location of D rsville	eath		County of Deeth	del
lc	Funeral Director		579-26-0188	Sex 1 □ M 2/DXF	7. Age (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bi Min. (Month, D 08/27)	rth ay, Year) /1924		plece (State or Foreign intry) ington, DC
	ryland how		Usual Residence of Decedent  10a. State  10b. County	1 1	10c. City, To							10d. Inside City Limits 1 ☐ Yesx 2 1 No
	he Ma 28a-f s	Director	Maryland Anne Ar	undel	MILL	ers	ville			10a Cit	lizen of What Cou	
	th with t	ai Dir	725 Crucible Co	urt			101. Zip 0000	21108		ÜSA		
336	d within 72 hours after death with the Maryland plane. I than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  † ☑ Widowed 4 ☐ Divorced	12. Was Dece Amed For 1 Tes If Yes, Give Year or Da	<b>X</b> ∑ No		Was Decedent of If Yes, specify Cu 1 ☐ Yes 🎗 🙀 No		? (Specify Yes or N uerto Rican, etc.)	0-	14. Race - Amer Black, White Specify: Wh	, etc.
Maryland 21215-0036	ithin 72 hours ne. nen "nature nedical E	Completed	15. Decedent's (Specify only highest g			(Give	dent's Usual Occi kind of work don DO NOT use retir	e during most of red)	working	16b. K	ind of Business/l	,
2	71 75 1		17. Father's Name (First, Middle, Las	st)			Homemak		Name (First, Middle	e, Maiden	In H	ome
land	T to the	To Be	James Everett W					Ethe	el Marie	Free	nan	
Mary	and and is m		19a. Informant's Name/Relationship Debra M. Haden /						Millersv			
	0 = 1		20a. Method of Disposition 1	☐Removal from S	20b. Place ceme	of Disponent	osition (Name of matory or other pi	ace)	Date /02/2004		ocation · City or 1	
Baltimore,	permit. Page Department o Important: If any injury or once.		* 4 □ Donation 5 □ Other (Special Signature *1 Funeral Service Lice		Ceda	2	2. Name and Add	ress of Facility George	P. Kalas	Fune	eral Hom	e P.A.
	40240		23a. Part1. Enter the disease, or co	mplications that ca	aused the death. D		6160_0xo	<u>n Hill l</u>	Road Oxon	Hil	l, Maryl	and 20745
1	Physician		shock, or heart failure." List on Immediate Cause (Final disease or condition	y one cause on ea	ENERAL DEB							Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (	or as a consequent	ce of):	DTCEACE					
	ped list	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (	of as a consequent	ga of):						
o,	execut an and rial-trar	Examiner	that initiated events resulting in death) Last		ARDIOVASCUI or as a consequent		ISEASE					
68760,	cate be chysicia the bu	dicai	•	d	TABETES ME	LTIU	S					
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 gnonths? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live bi	come of pregnancy inth 2 Fetal dea ant at time of death	ath 3	□Ectopic pregnan □ Other (specify)	су			23d. Date of deli Month	very Day Year
ds, P.O.	w requires that the standard by should be detact	by	Part II. Other significant conditions	contributing to de	eath but not resultin	g in the I	underlying cause (	given in Part I.	i			the cause of death?
Records,	The law req	Completed							24a. Wa aut per 1  Yes	opsy formed?	prior to c	topsy findings available completion of cause of
Vital		BeC	25. Was case referred to medical examiner?					26. Place of	Death (Check only			
Ţ	Q 12	To	1 ☐ Yes 2 🛣 No	-	npatient 2 ER		IN SU DOA		ng Home 51 Res			cify)
o uc	After		27. Manner of Death  1    Natural 5   Pending  2   Accident investigat		of Injury h, Day Year) 28	b. Time of Injury	W	ury at ork? □ Yes 2 □ No	28d. Describe	how inju	iry occurred	
Division of	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determine	be 28e. Place	of Injury · At home ng, etc. (Specify)	, larm, s		_	28f. Location	(Street allown, Stat		ral Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical Co		eminer: On the ba					place, and due to the occurred at the time			
	To the within To the	Me	29b. Signatur, and title of certifier	111	(2)	>	29c. Lice	nse number D 3755	1		e 29, 20	
	3		30. Name and a dress of person wh					on D	io Marral		21061	
	St	ate	Russell DeLuc	32. P	egistrar's Signature		4		ie, Maryl	anu	21001	
	Regist	-	31. Date liled (Month, Day, Year)	004 5	eneva	G	Spore	33				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 8:53 P M THOMAS **JERRY** HASTINGS June 26, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2896 Byrdtown Road Crisfield Somerset 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 219-34-3674 Yrs 73 February 2, 1931 Director Maryland Usual Residence of Decedent 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 X No Directo Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò 2896 Byrdtown Road Crisfield Itema 23a U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Innportant: if frem 27 is marked other then "natural", or lient eny injury or other traumatic event, the Medical Exercisions any injury or other traumatic event, the Medical Exercisions. Black, White, etc. XYes 2 No 1949-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White ģ 3 Widowed 4 Divorced 1991 Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) 8 Civil Service Employee Government, Dept. of Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas H. Hastings Jessie Cullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Hastings (Wife) 2896 Byrdtown Road - Crisfield, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Asbury Cemetery 6/29/04 \* 4 ☐ Donation 5 ☐ Other (Specify) Crisfield, MD 21. Signature of Fireral Service Lorsee

Robert H. Bradshaw, Jr. 22. Name and Address of Facility Fradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Angel andial **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner the willows is oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 5 Other (specify) P.O. ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 3 ☐ Probably 4 ☑ Onknown Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed2 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D 25036 July 1, 2004 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. R. Heda, M.D. - 614 Eastern Shore Drive - Salisbury, MD

State Registrar

DHMH 17 Rev 1/2001

JUL 0 7 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Reg. No. Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) 9:08 am **Physician** 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** of Baltimore Baltimore Cit Sinai Hospital city Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign **Funeral** 213-86-9656 Usual Residence of Decedent Days Months Hours 1 XM 2□ F Yrs. Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f shov other traumatic avent, the Modical Experiment and be natified at 1 Yes 2 □ No Maryland Completed by Funeral Director more 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code itams 23a or 1191 Vas Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. 14 Race American Indian. 11. Marital Status Black, White, etc. Yes G 1 ☐ Never Married 2 Married ō 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) anager 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ara (wile) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stat , Zip Code) Dept riment of Health a important: if itam 27 is any injury or othar tra once. on Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Pate 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 ☐Removal from State 2004 21. Signature of Funeral Servicy Licenses 22. Name and Address of JOS 23a. Par1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Salto Approximate Interval Between Onset and Death Immediate Cause (Final Physician week disease or condition resulting in death) /Medical Due to for as a consequence of): **Examiner** ptie Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 □ Yes 2 12 No 3 Probably 4 □Unknown filled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 21 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Yes 2 No Other: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funaral I Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To tha 29b. Signature and title of certifier 29c. License number reyo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Sinai arland F 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 07 2004 Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 5:35PM July 5 2004 Lewis Heath Halford /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Chesapeake Hospice House Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1⊠M 2□ F Yrs. 5, Director Feb. Mary Tand 220-46-1232 53 1951 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if lem 27 is marked other than "naturel", or Items 23s are never eny injury or other trainmain 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 21061 United States 179 Virginia Lane Apartment G Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates: 1970 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 € Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Heath Bennett Maude A. Heber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Leonard Ridge Court Nashville, Tennessee Stephen Halford - Brother 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) Crownsville MD 1 Purial 2. □ Cremation 3 □ Removal from State Crownsville, Maryland 5 Other (Specify) 21. Signi (e of Fun al Service icensee Kirkley-Ruddick Funeral Home P.A. 21061 421 Crain Highway S.E. Glen Burnie, Maryland Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Month /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Examiner burial-transit requires that the death certificate be executed Due to (or as a consequence of): led by the attending physicien detached for use as the buria Division of Vital Records. P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 res 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 NO 25. Was case referred to medical examiner? luspice Be 26. Place of Death (Check only one) Other: Hospital: House 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. Funerel Director: After to Certification: 27. Manner of Death 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) D39505 6,2004 MD ame and address of person who completed cause of death (Item 23a) (Type, Print) an M.D 300 1105171 21061 32. Registrar's Signature Delle ! State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** June 27, 2004 1:20 P. Hagler Bernice /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Fort Washington Hospital Fort Washington Prince George's 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea May 27, 1941 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min. Months Hours 1 ☐ M 2 🗓 F 63 579-54-4198 Washington, D.C. Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28a-1 show eny injury or other traumatic event, the Modical Examiner is used by notified at once. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County TXYes 2 □ No Prince George's Fort Washington Maryland Direct 10g. Citizen of What Country? 10e. Street and Number 12501 Asbury Drive 10f. Zip Code U.S.A. 20744 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced ieted 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Compi College (1-4or 5+) Elementary/Secondary (0-12) Social Worker United Comunity Against 2+18. Mother's Name (First, Middle, Maiden Sumame) Poverty 17. Father's Name (First, Middle, Last) Be Mable E. Johnson John H. Monroe 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Samuel L. Hagler (Husband) 12501 Asbury Drive Fort Washington, Maryland 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State July 2, 2004 Suitland, Maryland Cedar Hill Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROLLINS FUNERAL HOME, INC. 4339 HNT PLACE, N.E. WASHINGTON, D.C. 20019 ndols Approximate Interval Between Onset and Death rafil. Enter the disease, or complications that caused the death, hock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** ERHIHON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed for use as the burial-transit sura attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. Il yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probabiy 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 ☐ Yes Hospitel or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 TYes 2 ER/Outpatient 3 DOA After this 27. Manner of Ceath 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funaral Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of 10

State Registrar

3以 07 2004

31. Date liled (Month, Day, Yeer)

Samuel J. Kleiman, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

& Sports

11711 Livingston Road Fort Washington, Maryland 20744

			1 - For State Registrar	State of	Maryland / I		rtment of H				iene 	21255	
ı	Physici		Decedent's Name (First, Middle, Last)	Jar	nnie Jari	rott			2	. Date of Deat	7	3. Time of Death	
ů.	/Medic Examin		4a. Facility Name (If not institution, give s	treet and numb	er)		4b. City, Town, o	r Location	of Death Baltimo	re	4c. County of D	eath N/A	
	Funeral Director		(Stella Maris)  5. Social Security Number  238-10-7043  6. Sex		Age (In yrs. last bii 85	$\overline{}$	If Under 1 Year Months Days	If Under Hours		Date of Birth (Month, Day, Nov 11,	Year)	Birthplace (State or Foreign Country)	
	aryland show		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loc	cation					10d. Inside City Limits	
	the Mar 28a-f sh potified	Funeral Director	Maryland N/A				Ba	altimore		10	0g. Citizen of What	1 Yes 2 No	
	23e or	rai Di	3800 W . Belvedere Ave. A	\pt 603				2121	15			S.A.	
036	be filed within 72 hours after death with the Maryland tall hygiene.  d other than "netural", or Itams 23e or 28e-f show avent, the Medical Examinat roual be notified at	by	11. Marital Status  1 Never Married 2 Married  3 Nover Married 2 Divorced	<ol> <li>Was Decede Armed Force</li> <li>1 ☐ Yes 2</li> <li>If Yes, Give Year or Date</li> </ol>	⊠ No	If	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 🔀 No	lispanic Ori an, Mexicar Specify:	n, Puerto Rio	Specify Yes or North Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: Black			
15-0	in 72 hc "netur	Completed	15. Decedent's Educ (Specify only highest grade	completed)		(Give I	ent's Usual Occup kind of work done OO NOT use retired	during mos	st of working		16b. Kind of Busine		
1212	e filed within al Hygiene. I other then "vent, the Med		Elementary/Secondary (0-12)	College (1-4	or 5+)		Hom	emakeı				lome	
land	uld be fil fental H rked ott	To Be	17. Father's Name (First, Middle, Last)  Evans J	arrott				18. Mothe	ers Name (F		Maiden Sumame) nie Jarrott		
Maryland 21215-0036	s 1 and 2 should be f Health and Mental litem 27 Is marked of other treumatic ave		19a. Informant's Name/Relationship (Type	ne, Print)	196						, City or Town, State d 21215	a, Zip Code)	
Baltimore, I	C = N L   Altitul Couldolough										20c. Location - City	or Town, State	
Balti										Home P.A more, MD	۱ 21217		
	Physician		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on eac	sed the death. Do h line. tracran				cardiac or r	espiratory arre	est,	Approximate Interval Between Onset and Death Days	
	/Medical Examiner			Haz	as a consequence							Years	
	ted sit	Examiner	if any, leading to immediate cause. Litter Underlying Cause (Disease or injury		as a consequence								
8760,	cate be executed obysician and the burial-transit	dicai Exa	that initiated events resulting in death) Last	Due to (or	as a consequence	of):							
.O. Box 68	The law requires that the death certifica tie has been signed by the attending ph age 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🍱 No 9 □ Unknown	1 Live birth	me of pregnancy n 2 □ Fetal death t at time of death n		Ectopic pregnancy Other (specify)	,			23d. Date of o	delivery Day Year	
<b>a</b>	quires that en signed b ould be deta	by	Part II. Other significant conditions con Diabetes Mellit		h but not resulting i	n the un	derlying cause gre	en in Part I				to the cause of death?  Probably 4 JUnknown	
Il Records,										24a. Was ar autopsy perform 1 Yes 2	y prior t	autopsy findings available o completion of cause of ?	
Vital	ysic s ce direc	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:	atient 2 ☐ ER/Ou	utpatient	3⊡ DOA Oth	05		Check only one	nce 6 <b>X</b> Other (S	iospice pecify)	
on of	ing After une	Jon: T	27. Manner of Death  1 Natural 5 Pending	28a. Date of l (Month,		Time of Injury	28c. Injun Worl	y at	280		w injury occurred		
Division	tand leath tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined		Injury - At home, fa , etc. <i>(Specify)</i>	arm, stre		-		Location (Str City or Town		Rural Route Number,	
	To the Hospital or At within 24 hours after of To the Funerel Dirac completely filled in by	edical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	ician: To the be ar: On the basi and manner	s of examination ar	e, death	occurred at the tin estigation, in my o	ne, date an pinion, dea	nd place, and th occurred	d due to the ca at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Ros.			29c. Licenso	number	930	29	July T	nth, Day, Year)	
	3		30. Name and address of person who col			(Туре, Р	Print)	- 1	, 20			1 000	
	. Sta	ite	301 St Paul Place Baltim 31. Date filed (Month, Day, Year)			4	lac 1						
	Registr	ar	JUL 0 7 200	4	pero 1	<i>\( \)</i>	Spork	Y					

-4341 3		State of Maryland / Department o		ene
Unpend	ite	m State Registrar #23a, 27, 28a-f, per me, G834, 8/20/16/14		g. No? 11 1 2 2 56
Phys	ician	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year
	dical niner	Mickey Ray Jarvis  4a. Facility Name (If not institution, give street and number)  4b. City, Tow	July 3	4c. County of Death
Exam	nner	1216 Hillside Drive Pasade		Anne Arundel
Funer	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	ear If Under 24 Hrs. 8. Date of Birth	9 Birthplace (State or Foreign
Direct	or	217-94-1788 194 38 Yrs.	Dec. 21	
land land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Marylan of show	ţ	Maryland Anne Arundel P	asadena	1 ☐ Yes 2 ☒ No
ith the M or 28e-f	Director	10e. Street and Number 10f. Zip Coo		g. Citizen of What Country?
ath wi	ral	1216 Hillside Drive	21122	USA
ler death w items 23a	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent If Yes, specify (	of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
Ind 21215-0036 be filed within 72 hours after death with the Maryland tlat Hygiene. d other then "naturel", or items 23a or 28e-f show event, the Medical Examinat mout be notified at	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes 2 ☒ If Yes, Give 1 □ Yes 2 ☒ If Yes, Give 1 □ Yes 2 ☒ If Yes 2 ☒ If Yes If	No Specify:	Specify: White
5-003	ted	15. Decedent's Education 16a. Decedent's Usual October 15 and think and the standard of the st	ccupation 1	6b. Kind of Business/Industry
215 ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	itired)	
a filed within the Hygiene.		10 Disab	18. Mother's Name (First, Middle, M.	N/A
	) Be	James Jarvis		orhead
re, Marylanc s 1 and 2 should be f f Health and Mental I item 27 Is marked of other treumatic eve	2		reet and Number or Rural Route Number,	
C = 04 F	1	Barbara Jarvis (mother) 1216 Hillsi	de Drive, Pasadena,	MD 21122
000		20a. Method of Disposition 1 ☐ Burial 2 ☐ ★Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other)	place) July Date 06	Oc. Location - City or Town, State
Baltimor permit. Pages Department of I		`4 □Donation 5 □Other (Specify) Metro Crematory	Inc. 2004 B	altimore, Maryland
Salt bermit Depart mpoor	- Bouce	21. Signature of Funeral Service Ucenside 22. Name and Ac	Julings	Funeral Home, P.A.
- 4024			untain Road, Pasade	
Divisiois		23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Narcotic Intoxication	o, ing, out a data and on toop hater, and	Interval Between Onset and Death
Physicia /Medic		disease or condition resulting in death)  Due to (or as a consequence of):		
Examin	er			
p =	ner	Sequentially list conditions, if any, wording to introduce cause. Enter Underlying Cause (Disease or injury that initiated events c.		
60, be executed iician and burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):		
8760, cate be ex		Dua to (or as a consequence or).		
	edical	d.		
Box 6: auth certific attending p for use as	In/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregna	2007	23d. Date of delivery
O. B. ne death the atte	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify		Month Day Year
P.O. that the ded by the detached	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause	220 Did toh	acco use contribute to the cause of death?
dS, F irres that signed d be de	1 by	Part II. Other argumeant conditions contributing to death out not resulting in the underlying cause	g given in Fart i. 236. Did toba	. /
Cord  * require  been s  should	ete		24a. Was an	24b. Were autopsy findings available
Vital Records, sicien: The law requires the certificate has been signe rector, page 2 should be certor.	Completed		autopsy perform	prior to completion of cause of death?
Vital Ficien: The certificate	(D)	25. Was case referred to medical	26. Place of Death (Check only one	
of Vita Physicien: rrthis certific oral director,	To B	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residen	ce 6 StOther (Specify) at scene
			njury at 28d. Describe how Work?	v injury occurred
Division  Tor Attending after death. Director: After	icat		1 Yes No Unknow	n pet and Number or Rural Route Number.
Div A after Direct Tinby	Certification:	3 Suicide 4 ☐ Homicide  38e. Place of Injury · At home, farm, street, factory, offi building, etc. (Specify)  Found at Residence	1216 Hil	Iside Drive
Divisit  To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the basis of examination and/or investigation, in many and manner stated.	e time, date and place, and due to the cau	se(s) and manner as stated.
To the within 2 To the complet	<u>⊼</u>		ense number 296	d. Date signed (Month, Day, Year)
		Mayite melstrile in o.c.	M.E.	July 4, 2004
-		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	nn Street, Baltimor	re, Maryland 21201
- 44	strar	JUL 0 7 2004 Jan 18 Comples		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** HATTIE GERTRUDE JACKSON JULY 3,2004 4:55A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE RUXTON / PIKESVILLE NURSING HOME PIKESVILLE
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yo OCT • 10 9. Birthplace (State or Foreign **Funeral** Days Year) 1924 VIRGINIA 1□M 2 F Yrs **Director** 215 24 6903 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show MD. N/A 1 Yes 2 No BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5208 DENMORE AVENUE 21215 U.S. OF A death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No BLACK Specify β 3 ☐ Widowed 4 ☐ Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) SCHOOL TEACHER 12TH PUBLIC SCHOOL UNKNOWN other 17 Father's Name (First, Middle, Last) ABRAHAM BROWN 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any july or other treumatic event 2008. CARRIE BROOKS ပ ALEXANDER JACKSON (HUSBAND) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 20a. Method of Disposition

1 Buriai 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ARBUTUS MEMORIAL PARK 7/8/04 ARBUTUS, MARYLAND 21. Signature of Fineral Service License LEWTS nd rddres GWYNN FUNERAL HOME 21215-6393 **GWYNN** PARK HEIGHTS Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on bach line. ATHEROSCLEROTIC Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the at e detached fo 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ONGESTIVE EBRI 1 Yes 2 No 3 Probably # Unknown NON SCHAEMIL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 21 ☑ No 4 A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Ihis : After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Medicai Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. filled in by the 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funerel Direct completely filled in by 4 \ Homicide 부턴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manger stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

IATNEEM

31. Date filed JOE. 7922004

Box 68760

o

Division of Vital Records, P.

7220

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

AKHANI

32 Registrar's Signature

04

DHMH 17 Rev 1/2001

0 7 2004

		For State Registrar	State of Marylan		artment of H		nd Mental Hy	/giene	1000	21250
		Decedent's Name (First, Middle, Last)	)			······································	2. Date of D Month	eath Day	Year	3. Time of Death
Physic /Med		Walter	P. Kemp	-			July		004	9:15am
Exami		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	Location of	Death	4c.	County of Death Baltir	
		420 Riverside D			Essex	T. W.U				
Funeral Director		213-07-2009	7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 92	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of B (Month, D	ay, Year)	Cou	place (Stete or Foreign cyland
pug *		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
Aaryli Febo	ō	MD Baltimo	ore	Es	ssex					1 ☐ Yes 2 ☐ <b>X</b> No
the the 28a-	rect	10e. Street and Number			10f. Zip Code			10g. Citi:	zen of What Cou	intry?
death with the Maryland ms 23a or 28a-f show circust be notified at	Funeral Director	420 Riverside	Drive			21221		US	A	
death	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H	ispanic Origin	n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Ameri Black, White	
after or Its	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 XNo If Yes, Give		1 ☐ Yes 2 ☐ <b>x</b> No	Specify:			Specify:Whi	
hours af	d by	3 🛣 Widowed 4 ☐ Divorced	Year or Dates:							
nat nat	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most o	of working		nd of Business/Ir	
withir then	m d	Elementary/Secondary (0-12)	College (1-4or 5+)	Owne		,		Kellij	рѕпагеч	wareStore
Hygin Hygin	Ö	8th 17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, Middle	e, Maiden	Sumame)	
yiand buld be fill Mental Hy arked oth attic even	To B	Peter E. Kemp				Ida 1	Brick			
shound M		19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Maili	ng Address (Street	and Number	or Rural Route Numi	ber, City or	r Town, State, Zi	p Code)
and 2 sh alth and 27 is n		Philip Kemp /	son	116	PeachTre	eeRoa	d Ocean			1842
of He		20a. Method of Disposition  12 Burial 2 □ Cremation 3 □ I		cemetery, crea	osition (Name of matory or other place	(e)	Date / 7 / 0 4		cation - City or T	
Pag ment ant: b		'4 □Donation 5 □ Other (Specify,			Cemeter		/7/04		timore	
BAILIMOTE, MATYIANG ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madded Exarcher traumatic and once.		21. Signature of Funeral Service Licens	d (A	1 Pr 2	2. Name and Addres	ss of Facility	Connelly	yFund	eralHore	meofEssex
1		23a. Part1. Enter the disease, or comp shock, or heart failure. List o	I flons that caused the deal	a. De not en	ter the mode of dyin	g, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	C 14	Rouse	RG-RA	LTolor	(116 a 6	2	20	Onset and Death
/Medical		resulting in death)	aDue to (or as a consect	juence of):	1/12/	1	C171 4 1	ner	7	27
Examiner		Sequentially list conditions,	b	Day	Bw TIA					lyres
D sit	Examiner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a curiseq	uence of).						
<b>5U,</b> be executician and burial-tran	хап	that initiated events resulting in death) Last	c.  Due to (or as a consequence)	uence of):						
	ical E		d							
. BOX 68/ death certificate e attending phys d for use as the			0.		5117 4.0 <sub>00</sub> 10.0					
BOX 68 eath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		75			2	23d. Date of deliv	very
Geatte e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta		□Ectopic pregnancy □ Other (specify)				Month	Day Year
tache	Physician/Med	9 □ Unknown	9□ Unknown							
ords, F.C. requires that the despensioned by the a	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.				the cause of death? bably 4 □Unknown
w requir been si should b	Completed						-   '-	Yes 2	210 30110	
	npie							opsy	24b. Were aut prior to co death?	opsy findings available ompletion of cause of
The law	S							formed? 2 No	1 Yes	2 □ No
VITAL P Bician: Th certificate rector. pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		of Death (Check only			
Of Vita Physician: rthis certific ral director.	7	1 ☐ Yes 2 ☐ No 27. Manner of Death	1   Inpatient 2	ER/Outpaties 28b. Time o			sing Home 5 🔀 Res 28d. Describe			(fy)
	ion	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Wor	k? Yes 2 ⊟ No		, now injur	y occurred	
DIVISION for Attending after death. Director: After	fica	3 ☐ Suicide 6 ☐ Could not be	286. Place of injury - At n	ome, farm, st			28f. Location			al Route Number,
5 4 5 5	Certification;	4 Homicide	building, etc. (Speci.	fy)			City or 1	own, State,	)	
To the Hospitel within 24 hours a To the Funerel I completely filled	Medical C		vsician: To the best of my knoiner: On the basis of examina and manner stated.							
To the within 2 To the complei	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Dat	e signed (Month	Dey, Year)
F 3 F 8		•			DI	42:	2/	-/	7. 6. og	
1	X	30. Name and address of person who d	ompleted cause of death (Iter	m 23a) (Type,	71.0	····				
			21, 22	3 5-	BWO B	217	mp 21	221		
S	tate	31. Date filed (Month, Day, Year) 04	12 Registras Sign	atura	sports					

unpend item#23a,27,28a-f,PFR ME,C833,7/26/04e9
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. David Knight 04 - 4242State of Maryland / Department of Health and Mental Hygiene For State Registrar **AKG** Certificate of Death Reg. Ne. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** June 28, 2004 5:32 P <sup>M</sup> David L. Knight Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1100 Cedar Cliff Drive Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Birthplace (State or Foreign Country) Months 1 ★ M 2 □ F Director July 30, 1959 217-56-2536 44 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 Is marked other then "neturel", or Items 23s or 28a-f show other traumatic event, the Medical Event and must be notified at 1 ☐ Yes 2 ☐ No Director MARYLAND GLEN BURNIE ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 1100 CEDAR CLIFF DRIVE 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: à WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 is marked other then any injury or other traumatic avent Elementary/Secondary (0-12) College (1-4or 5+) 9 SUPERVISING MECHANICAL ENGINEER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be VELMA SNELGROVE CLARENCE KNIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 392 CARRONADE WAY ARNOLD, MARYLAND 21012 JAMIE L. KNIGHT DAUGHTER Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July  $\overset{\mathsf{Date}}{1}$ 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 METRO CREMATORY CATONSVILLE. MD 21. Signatur / Funeral Service Licensee 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME P.A. baug 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

210. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death Immediate Cause (Final Heroin & Cocaine Intoxication Prosician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Box 68760. attending physician certificate be Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) \_ Division of Vital Records, P.O. 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No 24a. Was an autopsy performed? 1X Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 XX ther (Specify) P 1 XYes 2 ☐ No at scene this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funerel Director: After 5 Pending investigation 1 Natural 6/27/04 found 5:30p 1 ☐ Yes 2 🗶 No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide 1100 Cedar Cliff Drive, Glen Burnie, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 29. 2004 O.C.M.E. Joshu 3 Gueshers MD

30. Name and address of person who completed cause of Sh (Item 23a) (Type, Print) Tasha Z Greenberg M.D 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 0 7 2004

				State of Marylar	Certifica				gierie Reg. Nø. 🗍 🎵	1, 21	261
	Physici	an	1. Decedent's Name (First, Middle, Las ELIZABETH DAV	/ENPORT PLAI	NT KING			2. Date of Dea	/ Day	Year /	me of Death
Y	/Medic Examin	al	4a. Facility Name (If not institution, give				4b. City, Town, or L BALTIMOF	ocation of Death	4c. County of		90.7.7
	Funeral Director		5. Social Security Number 6. S 2 5 3 - 20 - 0 3 9 4 1	ex	. last birthday) If Und Yrs. Month	der 1 Year is Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 09/04/	h y, <i>Year</i> ) 1919 (	9. Birthplace (S. Country) GEORGI.	
	ryland how		Usual Residence of Decedent  10a. State 10b. County MD		ity, Town or Location						ide City Limits
	the Ma	Funeral Director	10a. Street and Number			Zip Code			10g. Citizen of Wh		Yes 2 No
	s 23a or	ral DI	830 WEST 40th		I.C. In Was De		211	and the Man are blo	USA	- American India	an an
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	٤	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in L Armed Forces? 1 □Yes 2M No If Yes, Give Year or Dates:			lispanic Origin? (Span, Mexican, Puerto Specify:	o Rican, etc.)		White, etc.	arı,
21215-0020	n 72 ho "natur edical	leted	15. Decedent's Ec (Specify only highest gra	de completed)	16a. Decedent's U (Give kind of the life. DO NOT INTERIO	sual Occup work done use retired	ation during most of world)	king	16b. Kind of Busi	iness/Industry	
	ed withi ygiene. ier than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	INTERIO	)R DE				IOR DE	SIGN
Maryland	uld be fil Aental H rked ott tic ever	To Be	17. Father's Name (First, Middle, Last) GRAEME DICKERM	AN PLANT					Maiden Surname, AVENPO		
	nd 2 sho alth and P 27 is ma ir trauma		19a. Informant's Name/Relationship ( LEIGHTON K • WH)	<sup>'ype, Print)</sup> EELER daugh	19b. Mailing Addre	ess <i>(Street</i> VTHOF	and Number or Ru RN RD • I	ral Route Numbe BALTIMO	PRE, MD	tate, Zip Code) 21210	
Baltimore,	Pages 1 a ment of Hes ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Place of Disposition (A cemetery, crematory of EENMOUNT	CREN	1			LTIMOR	E,MD.
Balt	730 001 4300								IKTON, N		
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each line.  Physician								rest,	Approx Interva Onset	ximata al Between and Death
).	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. End-starg	ge alziber	ver 's	disease	e		644	ears
	P #	Iner		Due to'(	or as a conséquence o	of):					
oʻ	icate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (	or as a consequence o	i):					
68760,	tificate be execut ig physician and as the bunal-trar	edical	Cause (Disease or injury that initiated events resulting in death) Last	Due to (	or as a consequence o	f):	4. 4. 4. 4.				
Box	death certi e attending ed for use a	lan/M		d							
P.O.	- 0 D	Physician/	Part II. Other eignificant conditions of	Intributing to death but not re	sulting in the underlyin	g cause giv	en in Part I.		obacco use contr res 2⊡No 3		
rds,	w requires that the been signed by th should be detache	2	1000					24a. Was	an autopsy	24b. Were auto	opsy findings
3eco	elaw hasb	Completed							_/	completion of death?	n of cause
ital	E age	Be Co	25. Was case referred to medical				26. Place of Dea	1 □ Y th (Check only o		1 Tes	2∐ No
of V	Physician: rthis certific rral director,	2	examiner? 1 Yes 2 No	,	ER/Outpatient 3		4 La Nursing H		lence 6 Other	1 , , , ,	
ion	After After fune	atlon:	27. Manner of Death 1 DNatural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injur Wor 1 □	yat k? Yes 2 □ No	28d. Describe n	ow injury occurred	1	
Division of Vital Records,	를 <b>급</b> 불 o	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Special	nome, farm, street, fact ify)	ory, office		28f. Location (5 City or Tow	Street and Number m, State)	or Rural Route	Number,
	Hospital 24 hours Funeral stely filled	edical		yeician: To the best of my known the state of my known the state of examination and manner stated.							use(s)
	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, You						ar)				
	My babelle la gregor 19 013657 July 0,2004							2004			
_	7		30. Name and address of person who.			EET,	BALTIM	RE, MA	RYLAND	21211	•
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign		20. 1					

			1- For Amend Item #20b-c &22 per in 683	artment of Health and Martificate of Death	lental Hygie	ne พ.ก.ก.	21262
			Decedent's Name (First, Middle, Last)		2. Date of Death	<del></del>	3. Time or Death
П	Physicia /Medic		Mary Jane Kirk		June 23	Day 2004 Year	9:10 PM M
}	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Suburban Hospital	Bethesda		Montgomer	У
п	Funeral		5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)  5.56-26-5116  1 □ M 2 ☒ F  85  Yrs.	) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye July 22,	9. Birth	place (State or Foreign ntry)
	Director		556-26-5116 Super State		July 22,	1918 Nev	ada
	yland		10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits
	a-fet	ctor	MD Montgomery Bet	hesda			1 ☐ Yes 2√ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	ath w	rai	5101 Westwood Avenue	20816		USA	
	er de Items	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ② No	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	rs aft	by F	1  Never Married 2  Married 1	1 ☐ Yes 2X No Specify:		Specify: wh	nite
Š	filed within 72 hours after death with the Maryland Hygione. ther then "natural", or Items 23a or 28a-f ehow ther, the Macacal Examinar must be multiled at	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b	. Kind of Business/In	dustry
212	hin 7.	Completed	(Specify only highest grade completed) (Giv life.	e kind of work done during most of work DO NOT use retired)	ng		
7	filed with Hygiene. Ither ther	Com	12 2	draftsperson		patents	i
Maryland 21215-0036		Be	17. Father's Name (First, Middle, Last)  Madison Anderson		(First, Middle, Maid	den Sumame)	
<u>X</u>	2 should be and Mental Is marked o	٥			McQuiddy		
a Z	12 sh h and 7 Is m traum			ing Address (Street and Number or Rura		*	
	is 1 and 2 should of Health and Mer Item 27 Is marke other traumatic		20a Method of Disposition 20b, Place of Disp	Rhode Island Ave N		Shington I Location - City or To	
Baltimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	ematory or other place)		resolver and a	**
			21 Street up of Funeral Selvice Licensee	ce Crematory 7/7/(2. N me and Addless of Facility Rap	Funeral	Service	Nd
ñ	permit. Departr Importe any inji		Ronald Wade, Wirector		SP AVE	diaere S d2 <b>0</b> 910	treet
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a Pulmondry	emphali			Onset and Death
	/Medical		resulting in death)  a	1 Dr.			
	Examiner		Sequentially list conditions b. Protein S	deficiency			
	±	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events c				
8/60,	te be executed ysician and e burial-transit	al E	bus to (or as a consequence on).				
289	4 5 E	edical	d				
ROX	it the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ery
ň	death e atte d for	Icia	in the past 12 months?  1 Ves 2 700 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year
J.	t the by the tache	hys	9 □Unknown				
	The law requires that the tee has been signed by th bage 2 should be detache	ру Р	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	
ecords,	w require been si should t		folycythemia vera		1 Ves	2 No 3 Prot	pably 4 Unknown
ပို	law ras be	Completed	tracture of clavicle		24a. Was an autopsy	prior to co.	psy findings available mpletion of cause of
<u> </u>		Con	Fracture of ribs		performed 1 ☐ Yes 2 ☐	death? No 1 ☐ Yes	2 No
Vital H	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
0	Phys this al dir	. To	1 Yes 2 □ No Hospital: 1 Inpatient 2 □ EP/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time		me 5 Residence	6 Other (Specif	y)
o	ding F th. After funera	ertification:	1 □ Natural 5 □ Pending (Month, Day Year) Injury 2 Accident investigation (Tune 13, 2004 5, 30	Work?	Pall	ijary occurred	
Division	al or Attendii after death. I Director: A d in by the fu	fica	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm, s			and Number or Rura	al Route Nymber,
S	ppitel or ours after ours after ours after ours filled in the	erti	4 Homicide Getermined building, etc. (Specify)	at Westwood	City or Town, St	reld Rd. Bo	Hasda MD
	To the Hospitel or Attending Physicien: within 24 hours attended: To the Furnesel Director: To the Tracel Director: Completely filled in by the funeral director.	cal C	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the cause	e(s) and manner as s	tated.
	in 24 in 24 ihe Fu	edical	one) and manner stated.	ivestigation, in my opinion, death occurr	-		
	To To Com	Σ	29b. Signature and title of certifier Tomske Nay, Mis	29c. License number		Date signed (Month,	
					U	une 20,	2004
			30 Name and address of person, who completed cause of death (Item 23a) (Type Patricia Tomsko Nay, 6/2/ Montr	ase Road, Rock	ville,	une 28, MD 20.	852
	Sta Registr		31. Date (iled (Month, Day, Year) 32. Registrar's Signature	Sports			

			1- For State Registrar	State of M		artment of I	lealth and	Mental Hygie	AAAI	21263
	Physici	an	Decedent's Name (First, Middle,	•	3			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Media		DAVID F	AUL LEI	HMAN				4 200	
	Examir		4a. Facility Name (If not institution,	,		-	or Location of Dea	th	4c. County of Dea	
				HOSPITAL			MORE			IMORE
	Funeral Director		5. Social Security Number  212-56-5864  Usual Residence of Decedent	5. Sex 7. Ag 1 ☑ M 2 □ F	ge (In yrs. last birthday 53 Yrs.	Months Days			1951 9. Bi	rthplace (State or Foreign Country)
	land ow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	f sh	ō	Maryland Anne	Arundel		Pa	ısadena			1 ☐ Yes 2 📉 No
	the 28e	by Funeral Director	10e. Street and Number	711 411461	1	10f. Zip Code	Jaacha	10a.	Citizen of What C	country?
	3e or	0	7892 Bellhave	n Dood			21122			,
	ms 2	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13	Was Decedent of I		Specify Yes or No-	14. Race - Am	
(Q	or Ite	F	1 ☐ Never Married 2 ☐ Marrie	Armed Forces? d 1 ☐ Yes 2 🛣	No			rto Rican, etc.)	Black, Wh	ite, etc.
Ö	el', c	b	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify:	White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other then "neturel", or Items 23e or 28e-f show ent, it e Mauleal Examiner must be notified at	Completed	15. Decedent's (Specify only highest	Education	16a. Dec	edent's Usual Occup	pation	ndein a	. Kind of Business	,
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	e kind of work done DO NOT use retire		,g		ndel County
	filed with Hygiene ither the	Ö		4	Maii	rtenence/			Scho	0018
pu	be fill d off	Be	17. Father's Name (First, Middle, La David Willi		2			me (First, Middle, Maid		
<u>Y</u>	2 should be fi and Mental H Is marked of feumatic ever	2					Marge			
Maryland	12 st n and r Is n		19a. Informant's Name/Relationshi					lural Route Number, Ci		Zip Code)
	1 and Health tem 27 other tr		Margery Lehman 20a. Method of Disposition	(mother		Arundel		sadena, <u>MD</u>	21122 Location - City or	Taura State
ō	Pages nent of h int: If its iry or of		1 ☑ Burial 2 ☐ Cremation 3			osition (Name of omatory or other pla	E 0 U I	y 08		
ŧΪ	t. Partmer		`4 □Donation 5 □ Other (Spe			el Cemete		004 Pa	sadena, I	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show amy njury or other treumatic event, it's Madical Examiner must be notified at ones.		21. Signature of European Service	7.			tain Roa	d, Pasadena		il Home, P.A. 22
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused nly one cause on each li	d the death. Do not er ine.	nter the mode of dyin	ng, such as cardia	c or respiratory arrest,		Approximate Interval Between
4	Priysician		Immediate Cause (Final disease or condition	HI	EPATIC 1	ENCEPH	MALOPA	YHTF		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
	Lxammer		Sequentially list conditions,	b. RE		ILURE				18 lus
	sit ad	Examiner	Sequentially list conditions, in any, leading to infinediate cause. Enter Underlying Cause (Disease or injury)	Die to (or as	a consequence of):					
	and -tran	cam	that initiated events resulting in death) Last	c. Due to for se	a consequence of):					
60,	be executed sician and burial-transit	E		Due to (or as	a consequence or).					
68760	physi the b	dicai		d.						
9 x	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outcome	of programov					
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	□Ectopic pregnanc	у		23d. Date of de Month	olivery Day Year
P.O.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant a 9☐ Unknown	t time of death 5	Other (specify)				
٥.	res that the designed by the a		Part II. Other significant condition	s contributing to death h	out not resulting in the	inderlying cause on	en in Part I	23e Did tobaco	o use contribute t	o the cause of death?
ds,	signe d be	d by		,		, , , , , , , , , , , , , , , , , , ,		1 ☐ Yes		robably 4 Unknown
Ö	w requir been s should	ete						-		
Records,	has be 2 s	Completed						24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
a	icien: The certificate ha ector, page							1 ☐ Yes 2 Ø		s 2 No
Vital	sicien: certifica rector.	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath (Check only one)		
o	Phys this ral di	- To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Z Inpatie		nt 3 DOA	4 Nursing I	Home 5 Residence		ecify)
no	ng ftel	File	1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	Year) Injury	Wor	rk? Yes 2 □ No	200. Describe flow ii	ijary occurred	
isi	uttendii death. ctor: A y the fu	lica	3 ☐ Suicide 6 ☐ Could no	t be	jury - At home, farm, si		100 2 110	28f. Location (Street	and Number or R	ural Route Number
Division	after Dire	Certification:	4  Homicide determin	building, et	c. (Specify)	reet, lactory, office		City or Town, St		arar roate reamber,
_	spitel ours nerel filled		29a. Certifier 1 Certifying	Physician: To the best	of my knowledge, dea	th occurred at the tir	me date and place	and due to the cause	(s) and manner a	hateta a
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	(Check only 2 Medical Ex	caminer: On the basis o	of examination and/or in	ivestigation, in my o	ppinion, death occ	urred at the time, date a	and place, and du	e to the cause(s)
	o thin ithin o the ompl	Me	29b. Signature and title of certifier			29c. Licens	e number	29d. I	Date signed (Moni	th, Day, Year)
	- s + ō		DA INTI	ERN		P-1	6772		07/4/5	
7			30. Name and address of person wi	no completed cause of r	leath (Item 23a) (Type	Print)	7 1 -	50110111111		
	4		RINDUKANA	APURU HA	RBOR HD	SPITAL	3001	SALTIMOS	ア、 NOV に NOV に に に に に に に に に に に に に	O LKCE
	Sta	te	31. Date filed (Month, Pay, Year)	200 / 32. Registr	ar's Signature		3	711-11110/	C/11100	XI XX X Z
34	Registr		31. Date filed (Month, Day, Year)	2004	and side the	mede				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Da **Physician** LUL 2004 Frederick Υ. Lee /Medical 4b. City, Town, or Location of Deat 4a. Facility Name (If not institution, give street and number) County of Death **Examiner** of Baltimore Baltimore HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Days Months Hours 1 □XM 2 □ F Director 217-67-9928 May 12,1954 Philippines Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f ahov traumatic avant, the Medical Examiner must be notified at 1X Yes 2 No Director MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 0 or Itams 23a 6810 Maple Leaf Court, Apt. 202 21209 Philippines Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ☐Yes 2 No f Yes. Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Asian 3 Widowed 4 Divorced Year or Dates: "netural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Salesman Brewery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental H ant: If itam 27 Is marked of 2 Roberto Lee Francisca Yap 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wife Crisalvea C. Lee 6810 Maple Leaf Court, Apt. 202, Baltimore, MD altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition Quezon City or Town, State Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Philippines Himlayang Pilipino 7/13/04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events physician and resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) be detached 1 ☐ Yes 2 ☐ No o. 9 Unknown 9 Unknown signed by ے 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2 No 1 Yes 2 No 1 Tes of Vital 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Watural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 Yes 2 No death. 2 Accident after death Diractor: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours a 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

State Registrar

31

32 Registrar's Signature JUL 07 2004

an

Date filed (Month, Day, Year)

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death Day Month Year **Physician** MOJOS 2004 /Medical wn, or Location of Death 4c. County of Death **Examiner** rs. last birthday) Yrs. If Under 24 Hrs. If Under 1 Year 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M 2 XF **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland City. Town or Location Inside City Limits 10a. 10b. County "natural", or Itams 23a or 28a-f show 1 Yes 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? American Indian, Was Deceder If Yes, specify Hispanic Origin? (Specify Yes or No-can, Mexican, Puerto Rican, etc.) 14. Race Black, White, etc. ☐Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 f Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced th and Mental Hygiene.
27 is marked other than "natur traumatic avent, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retiged) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Secondary (0-12) 17. Father's Name First, Middle, Last) Be liece 19b. Mailing Address (Street a permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 is any injury or other trau once. USCU 20b. Place 1 Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. ing, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine burial-transit certificate be executed the attending physician and resulting in death) Last Due to (or as a consequence of): Physiclan/Medical use as the IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by t page 2 should be detach Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has I autopsy performed? 1 ☐ Yes 2 No Vital To the Hospital or Attanding Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Tot Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3□ DOA Division of Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Matural Injury 5 Pending 2 🗌 No within 24 hours after death.

To the Funeral Diractor: A completely filled in by the fu 1 Tes investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖼 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2004 036508 mo SHAO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belvede ave

Registrar

State

Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - For State Registrer	State of	Marylar		artment of H rtificate of			F	Reg. No.2 0	)4	21266			
П	Physicia	an	Decedent's Name (First, Middle	, Last) Gloria N	#:loo	Dieba	rdcon		:	2. Date of Dea Month	ul 5, 2004	Year	3. Time of Death			
,	/Medic	al	4a. Facility Name (If not institution			Richa	4b. City, Town, o	or Location	of Death		4c. County	of Death				
1	Examin	er		oseph Richie Ho			, , , , , , , , , , , , , , , , , , ,		Baltimo	re	,	N//	_			
	Funeral		5. Social Security Number	6. Sex 7.		last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt	h /. Year)	9. Birth	pplace (State or Foreign			
	Director		214-84-1704	1 □ M ½ □ F	41	Yrs.				(Month, Day Aug 7,	1962	N	laryland			
	land		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits			
	Mary I-f sh	tor	Maryland	N/A			Ва	ltimore					Yes 2 No			
	th the	lrec	10e. Street and Number				10f. Zip Code				10g. Citizen of \		•			
	23a c	rai	1002 Shellbanks Roa					2122				U.S.A				
39	n 72 hours after death with the Maryland "naturel", or frams 23a or 28a-f show calcal Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedo Armed Force ied 1 ☐ Yes 2 If Yes, Give Year or Date	es? √□No	+	Was Decedent of Hif Yes, specify Cub			cify Yes or No- lican, etc.)	14. Rac Blac Specify	k, White	rican Indian, a, etc. Black			
20	72 ho	Completed	15. Decedent (Specify only highes		-	(Give	dent's Usual Occup kind of work done	during mos	t of working	a	16b. Kind of B	ısiness/I	ndustry			
21	- 2	mple	Elementary/Secondary (0-12)	College (1-4	lor 5+)	life.	DO NOT use retire	<sub>d)</sub> emaker				Hon	ne			
121	e filed withi Il Hygiena. other than		17. Father's Name (First, Middle,	l ast)			11011			(First. Middle.	Maiden Surnan	ne)				
land	should be in Mental I imarked or	To Be		vid Miles							ce Myers	,				
Maryland 21215-0036	and and is m		19a. Informant's Name/Relations				ng Address (Street 02 Shellbank									
	s 1 and 2 if Health itam 27 other tra		Grace Myers Mother 20a. Method of Disposition		20b. I	Place of Dispo	sition (Name of	1		ate T	20c. Location -					
nor	60	139	1 ☑ Burial 2 ☐ Cremation			cemetery, crei	matory or other pla	<i>св)</i>				-				
Baltimore,	permit. Pag Department Important: I any injury o					22	Name and Addre	ss of Facili	ty							
ä	Per Per Per Per Per Per Per Per Per Per		· Ceco G SA	Signature of Fund I Service Licensee    Condition   Co												
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	used the dear	th. Do not en							Approximate Interval Between			
	Pnysician	1.2	Immediate Cause (Final disease or condition		Onset and Death  13 9665											
	/Medical Examiner		resulting in death)	Due to (or	r as a consec	quence of);										
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liceas or if July)	b Due to (or	r as a consec	quence of):						-				
	cuted nd ransit	Examine	triat initiated events	C												
βď	ate be axecuted obysician and the burial-transit		resulting in death) Last	Due to (or	ras a consec	quence of):										
8760	cate b	dica		d												
P.O. Box 6	The law requires that the death certifica tte has been signed by the attanding ph page 2 should be detached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown		h 2 ∏Feta ntattime of o	aldeath 3	Ectopic pregnanc Other (specify)	у				te of deli	very Day Year			
	res that signed b	by Pt	Part II. Other significant condition	ons contributing to dea	th but not res	sulting in the u	nderlying cause gr	ven in Part I		23e. Did to	bacco use cont	ribute to	the cause of death?			
rds	w require been sig should b	ed t	HEPBITITS	C ; H	GP 147	CFK	LUKE			1921	'es 2 □ No	3 Pro	obably 4 🗍 Unknown			
eco	ne law requ has been ge 2 should	Completed	ENDOCARDO	1775'						24a. Was	SV	prior to c	topsy findings available completion of cause of			
Vital Records,		Com	SEVERE LON	ETTE INSA	IFFILL	5004	ACUE	PENA	C FKI	perfo		death?	2 No			
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Ott	hori		(Check only o	1					
of	S 5 5	.: To	1 Yes 2 No	1 ☐ Inp 28a. Date of (Month)		ER/Outpatier 28b. Time o	f 28c. Inju	ry at		ie 5 ☐ Resid 8d. Describe h	lence 6 th	er <i>(Spec</i> red	ity) HOSPICE			
	Attanding F r daath. ector: After by the funer	ition	1 Natural 5 Pendin	9	Day Year)	Injury	Wo	rk? ]Yes 2 🗌	No							
Division	or Attandi after daath. Director: A in by the fu	Certification;	3 Suicide 6 Could	ined 286. Place o	f Injury - At h	nome, farm, st	reet, factory, office		2	8f. Location (S City or Tow	Street and Numb	er or Ru	ral Route Number,			
Ö	ital or A irs after ral Directed in by								W <sub>1</sub>							
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	ng Physician: To the b Examiner: On the bas and manne	is of examina	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	ime, date ar opinion, dea	nd place, ar ath occurre	nd due to the o d at the time,	cause(s) and ma date and place,	inner as and due	stated. to the cause(s)			
	To the Within To the comple	Me	29b. Signature and title of certifie					se number			29d. Date signe					
	^		Jan	and mil	7		Dx	24	88		7-0	5-0	04			
	5		30. Name and address of person	who completed cause	of death (Ite	m 23a) (Type,	Print)			· MI	720-05	WAI	1 21215			
			LM. JUMAN	OY, M.D	1 2	20 741	VB PIDGO	5 Kl	KU,	BALL	Mart,	ME	2/2/2			
	Sta Regista		31. Date filed (Month, Day, Year) JUL 0 7 20		gistrar's Sign	4	park									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend Item #26 per phy G833 / // 194 Las

Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4:00 A. M Mills 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number HARFOR 6. Sex 1 1 1 1 1 2 □ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 239-01-2505 Yrs. Director V. Carolina Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director TIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21234 3022 items 23a ood Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2□No Specify: Specify: White 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) H+B Manutac 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Mathew D. M.11 Minnie 2 19a. Info II ant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Mills item 27 i 508 Halpress H. IARDORO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Depertment of H Importent: if ite any injury or ot 2006 Bardens of Faith Gene 17-6-04 rosedale mu \* 4 Donation 5 Dother (Specify) 22. Name and Address of Facility BALTI MORE MD 21234 21. Signature of Funeral Service Licensee -,8800 HARFORD RD EVANS FUNERAL CHAPEL 10 lu 23a. Part1. Enter the disease, of complications that caused the dearff, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence at) 6 MO /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of). attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. been signed by the should be detached 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 100 3 Probably 4 □Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2[] No 20 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Daughter-in-Other: 4 Nursing Home idence 6 X Other ( Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA dir idence 6 X Other (S baw's residence After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours after To the Funerel Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) 7/2/4 D44604

Registrar

State

MICHAEL

31. Date filed (Month, Day, Year)

SUTER

2004

Mathu

9512 HARFORD

person w o completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Miller, Frank altimore. Marvland 21215-0036

			CK Indelible Ink. Ensui Department of Health a		•
	1 - For State Registrar		Certificate of Death	Reg	N2004 21268
Physician /Medical	1. Decedent's Name (First, Middle, La FRANK J.	Miller, J	B	2. Date of Death Month	Day Year 3. Time of Death 5, 2004 11:02 a <sub>M</sub>
Examiner	4a. Facility Name (If not institution, git	1 1 - 1 1	4b. City, Town, or Location of	Death	4c. County of Death  Baltimore
Funeral		Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of Birth Min. (Month, Day, Y	Birthplace (State or Foreign
Director	Usual Residence of Decedent	12(M 2□F 73	) Yrs.	4)ov. 12,	1930 MARYLAND
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  I marked other than 'natural', or items 28a or 28a-f show other traumatic event, the Madical Examinat must be notified at the Completed by Funeral Director.	10a. State 10b. County  HARF		own or Location White Hall		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Site death with the Maintense 23s or 28s-1 solutions 23s or 28s-1 solutions and the maintenance of the control	10e. Street and Number 4130 Harford	Cronery Rd	10f. Zip Code	10g	Citizen of What Country?
r death	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
O36 ours afte rat, or it Examin	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑Yes 2 ☐ No I¥Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White
Maryland 21215-0036 To 2 should be filed within 72 hours aft till and Mental Hygiens and matural; or 27 is marked other than "natural; or rtraumatic event, the Medical Exami To Be Completed by F	15. Decedent's E (Specify only highest gr	ducation 10 ade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	of working	b. Kind of Business/Industry
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Menal Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, tra Ma	Elementary/Secondary (0-12)	College (1-4or 5+)	Federal Employee/E	Jectrician Al	perdeen Proving Ground
laryland 212 2 should be filed with and Mental Hygiene, and Mental Hygiene and metric event, the A To Be Com	17. Father's Name (First, Middle, Las	.00 1 H	18. Molher	's Name (First, Middle, Ma	iden Sumame)
should Ind Men on Men o	FRANK J.  19a. Informant's Name/Relationship	(Type, Print)	9b. Mailing Address (Street and Number	or Rural Route Number, C	ity or Town, State, Zip Code)
Ce, Ma	Vicki Kachno	1 A	OL Red Pump R	d. Bal Air,	MD 21014.
ges 1 and the littern or oth	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 [	☐Removal from State ceme	of Disposition (Name of other place)	Date 20	c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe once.	' 4 □ Donation ' 5 □ Other (Special Signature of Funeral Service Lice	M IEVANS	22. Name and Address of Facility	FOREST HIL	LIMO 21050
Balt permit. Depart Import any inji	Kimberly (	1. Burotic	EVANS FUNERAL	CHAPEL-BEL	AIR, 3NEW POET DR.
		pplications that caused the death. E	o not enter the mode of dying, such as c	ardiac or respiratory arrest	Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	a. <u>Metastatic</u> Due to (or as a consequence	lung cancer		
Examiner	Convention the line conditions	, respiratory	railure		
sit sit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	Due to (or as a consequence	ce of):		
760, le be executed risitian and e burial-transit cal Examiner	that initiated events resulting in death) Last	c. No Occo Unit	De of):		
3760, ate be ex nysician he burial		d			
Box 687 leath certificate attending phys for use as the	IF FEMALE:	23c. If yes, outcome of pregnancy			
O of the d	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 □ Fetal dead 4 □ Pregnant at time of death 9 □ Unknown	ath 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
S, P. (es that the igned by be detacted by Phy	Part II. Other significant conditions	contributing to death but not resultin	g in the underlying cause given in Part I.	23e. Did tobac	ouse contribute to the cause of death?
w require been sit should be	COPD			1 ☑ Yes	2 No 3 Probably 4 Unknown
on of Vital Records, sing Physician: The law requires the ther this certificate has been signe funeral director, page 2 should be continued. To Be Completed by				24a. Was an autopsy performed 1 ☐ Yes 2 ☑	
Vital F sician: Th certificate lirector, pag	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/	Othor	of Death (Check only one) sing Home 5 Residence	a. 6 🗆 Other (Conside)
Division of Vital or Attending Physician: alter death. Directors After this certification; In by the funeral director, I be the trification; To Be Certification; To Be Certification.	27. Manner of Death		p. Time of 28c. Injury at Injury Work?	28d. Describe how	
Sior tendin teath. tor: Af the fur	1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not I	on .	M 1 ☐ Yes 2 ☐ N		
Divi	4 Homicide determined		farm, street, factory, office	City or Town, S	t and Number or Rural Route Number, State)
Division C To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera Medical Certification;	29a. Certifier 1	hysicien: To the best of my knowled miner: On the basis of examination and manner stated.	dge, death occurred at the time, date and and/or investigation, in my opinion, death	place, and due to the caus a occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within 2 To the complet	29b. Signature and title of certifier	AIN	29c. License number	29d.	Date signed (Month, Day, Year)
h	20 Name and address of parson who	Completed cause of death (trees 33	a) (Type Print)		7/2/04
.5	30. Name and address of person who	IC a GAMAT	and (Type, Print) and Solution	rive Balti	more MD. 21237
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1	1	
Registrar	JUL 07 200	4 Olyeva	M Society		

)			For State Ragistrar	State of Ma		partment of hertificate of			giene Reg. NØ.	01060
			Decedent's Name (First, Middle,	Last)		711110010 07		2. Date of Dea	ith	3. Time of Death
	Physic Medi		Robert Howell I	Mace, Sr.				July 1	Day Year	0246 P <sup>M</sup>
>	Exami		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	or Location of Death	bury r	4c. County of Deat	
18.	146		Dorchester Gene			Cambrid			Dorchest	er
	Funeral		,	S. Sex 7. Age 1.XM 2□F	(In yrs. last birthday	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. Birth	nplace (State or Foreign
	Director		219-34-2115 Usual Residence of Decedent		69 Yrs.			12/15/		ryland
	/land		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Many a-f sh	tor	Virginia Prince	Williams	Nokes	ville				1 ☐ Yes 2 XXVo
	with the Marylan cor28a-1 show	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
	death with the Maryland ms 23s or 28a-f show Frivet be redified at	alD	14505 Fitzwater	Drive		201	L82		USA	
Maryland 21215-0036	72 hours after dea natural', or Items Joul Ever de retra	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 X No	Hispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specific	
2-0	72 ho	ted	15. Decedent's (Specify only highest	Education	16a. Dec	edent's Usual Occup	pation		16b. Kind of Business/l	
21	c = 33	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most of work d)	ing		
2	filed within Hygiene. othar than ent, the M		12		Ca	rpenter			Self-Emp	loyed
and		Be	17. Father's Name (First, Middle, La	ist)			18. Mother's Name		,	
2	s 1 and 2 should be fi f Health and Mental F itam 27 is marked ot othar traumatic evel	L C	Howell M. Mace	(Time Brint)	40h 14-1	E 4		Mae And		
Ma	d 2 si th an 7 is r traur		Norma Mace (w						r, City or Town, State, Z esville, VA	
	of Health of Health litam 27	11 3	20a. Method of Disposition	rre)	20b. Place of Disc	osition (Name of		-	20c. Location - City or 1	
nor	ages int of t: If it		1 Burial 2 XCremation 3		cemetery, cre	amatory or other pla	ce)			
Baltimore,	artme ortan injury		<ul><li>4 □ Donation 5 □ Other (Spe</li><li>21. Signature of Funeral Service Lie</li></ul>			22. Name and Addre	Inc. 07/0	-		, Maryland
Ba	permit. Pages 1 Department of H Important: If Ita any injury or ot		23a. Part 1. Enter the disease, or co	ssaln	1	1750 Bela	ir Road -	Kingsv	ille, MD 2	1 Home, P.A 1087
J.	/Medical Examiner	Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Athero  Due to (or as a  b. Due to (or as a c	consequence of):	Casdiovi	ascular	Disèus	e	Interval Batween Onset and Death
8760,	cate be e. physician the buria	dical E		d						
. Bo	death certifi e attending I od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	□Ectopic pregnancy	/		23d. Date of deliving Month	ery Day Year
<b>a</b>	w requires that the been signed by th should be detache	þÀ	Part II. Other significant condition	s contributing to death but	not resulting in the	underlying cause giv	en in Part I.		pacco use contribute to	4/
I Rec	The law ate has b page 2 st	Completed						24a. Was a autops perform	y prior to co ned? death?	opsy findings available ompletion of cause of
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	(I) 3-1			26. Place of Death	(Check only on		
of	hys this aldii	2	XXYes 2 No	Hospital:	-4.4		4   Nursing nor		ence 6 Other (Speci	fy)
	After After fune	Certification:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )	(ear) 28b. Time (	Wor	k?	28d. Describe ho	w injury occurred	
Sic	uttandi death. ctor: A y the fu	icat	2 Accident investigat 3 Suicide 6 Could no	be 200 Place of Injury	. At home form of		Yes 2 □No	20f Location /St	root and Number or Dur	at Carrie Museum
É		≒ I	4 Homicide determine	28e. Place of Injury building, etc.	(Specify)	reet, factory, onice	1	City or Town	reet and Number or Rur n, State)	ai Houte Number,
	lor A after Direc I in by	ē		110						
	Hospital or 4 hours afte Funaral Dir ely filled in b		29a. Certifier 1 Certifying (Check on) 2 Medical Ex	Physician: To the best of aminer: On the basis of earth manner state	xamination and/or it	th occurred at the tin	ne, date and place, a pinion, death occurre	and due to the ca ed at the time, da	ause(s) and manner as s ate and place, and due t	stated. the cause(s)
	Hospital or 4 hours afte Funaral Dir ely filled in b	Medical Cer	(Check only 2 X Medical Ex	aminer: On the basis of ea	xamination and/or it	th occurred at the tin evestigation, in my o	pinion, death occurre	ed at the time, do	ause(s) and manner as sate and place, and due to be detected and place. But all the same and place are sate and place and place are sate and place are sate and place are sate and place are sate and place are sate and place are sate and place are sate and place are sate and place are sate and place are sate and place are sate and place are sate and place are sate and place are sate and place are sate and place are sate and place and place are sate and place are sate and place are sate and place are sate and place are sate and place are sate and place are sate are s	o the cause(s)
	Dir.		one) 21 A Medical Ex	aminer: On the basis of ea	xamination and/or it	nvestigation, in my o	pinion, death occurre e number	ed at the time, da	ate and place, and due t	Day, Year)
	Hospital or 4 hours afte Funaral Dir ely filled in b		one) 21 A Medical Ex	aminer: On the basis of ea	th (Item 23a) (Type	29c. Licens O.C.	e number  M.E.	ed at the time, da	ate and place, and due to a signed (Month,	o the cause(s)  Day, Year)  4

DHMH 17 Rev 1/2001

JUL 07 2004

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) .<sup>Day</sup>2004 June 25, 10:30A M **Physician** Jean /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Collington Life Care Center Mitchellville If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 7/30/24 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 212 F 578-28-6973 79 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28a-1 show eny injury or other traumatic event, Ite Madical Examinat must be notified at Maryland Prince George 1 ☐ Yes 2 No Mitchellville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20721 10450 Lottsford Rd. Apt.224 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 2 10 10 11 Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: <u>م</u> Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Payroll Supervisor Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anne Rittenhouse Jean L. Armour 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8525 Dupew St. Arvada, CO. 80003 April Richey/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 7/2/04 Suitland, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Sovice Licensee 22. Name and Address Gleasinge P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** auc /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical tE FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? 1 ☐ Yes X 🛠 🙀 No this certificate To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home ၉ 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 27. Manner of Death XXNatural 5 Pending investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29d, Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and titte of certifie address of person who completed cause of death (Item 23a) (Type, Print) B316 Bowle, MD201/2 yere Mr 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ng. Decedent's Name (First, Middle, Last) 2. Date of Death Physician :15PM 2004 ULO Charles Scott Marple /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CILEN BURNIE ANNE AKUNDER NORTH APKINDEL HOSPITA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1X M 2 ☐ F 79 Yrs. Director Pennsylvania 5-7-1925 159-20-9998 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 200 No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1009 Jigger Court 21401 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 (∑Yes 2 □ No If Yes, Give Year or Dates: 1946–76 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ŏ Maryland 21215-0036 1 Yes 2 No Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) U.S. Coast Guard 12 5+ Captain rmit. Pages 1 and 2 should be filed w pertiment of Health and Mental Hygien portent: If item 27 is marked other tily injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert K. Marple Jane Haynie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Helen I. Marple / Wife 1009 Jigger Court Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 

©Cremation 3 ☐ Removal from State Kalas Crematory 7-2-2004 Edgewater, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Part 1. Enter the distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the dis Approximate Interval Between Onset and Death METHICILIN RESISTANT STAPHYLOCOCCUS ADIREUS PRIEHMONIA Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** DISEASE GORON ARM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner rsician and e burial-transit Physician: The law requires that the death certificate be executed MSPLASTIC MYELDE Due to (or as a consequence of) Box 68760. phys. the b attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 4 🗐 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 2 1 Yes 2 No 1 npatient 3 DOA 27. Mann of Death 1 Natural Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After or Attending 5 Pending death. 1 ☐ Yes 2 ☐ No investigation nours after death neral Director: / filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral C To the Hospitel 29a. Certifier 1🗲 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature at MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Prince ABAA) CY Then Burnie

State Registrar AMC

31. Date filed (Month, Day, Year)

JUL 07 2004

DHMH 17 Rev 1/2001

HOS

32 Registrar's Signature

MD

			For State Registrar	State	e of Ma	ryland /	•			ealth a		lental Hy	giene Reg. No. (	004	21272	>
	Division		1. Decedent's Name (First, Midd	le, Last)								2. Date of De	ath		3. Time of Deati	h
	Physici /Medio			Emme		tencer	. Ne	al, :	Jr.			July 4			9:10 P	М
	Examir	ner	4a. Fecility Name (If not institution	•	d number)			4b. City,		Location o	of Death			ounty of Deal		
			Gilchrist Cent  5. Social Security Number	6. Sex	7 400	(In yrs. last	hirthdou	If Under	TOWS	If Under	24 Hrs	8. Date of Bir			re Co.	n ian
	Funeral Director		218-42-6935	13 <b>2</b> M 2□			Yrs.	Months	Days	Hours	Min.	(Month, Da	9.194	3 Vir	hplace (State or Fore untry) ginia	sign
	ס		Usual Residence of Decedent													
	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Hygiene.	by Funeral Director	Maryland 10b. County	Baltimo	re	10c. City, To	own or Lo	cation			Col	gate			10d. Inside City Lim	
2	or 2	Dire	10e. Street and Number					10f. Zip	Code	2.	1004			of What Co		
\$	sath v	erai	7952 Gough St		Decedent E	ver in II S	12 1	Nos Docor	dont of Ui		1.224	acifu Vac or No		ted St	incan Indian,	
C	fter de	Fun	11. Marital Status  1X Never Married 2 Mai	rried Arme	ed Forces? Yes 2 □ N	0				n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)		Black, Whit		
0 /	al', o		3 ☐ Widowed 4 ☐ Divorce	lf Year	s, Give or Dates:V	ietnam	1 1	Yes	2 <b>√</b> No	Specify:			S	pecify: W	hite	
6116	netur Iteal	eted	15. Deceder (Specify only higher	nt's Education	ited)	16	6a. Deced	lent's Usua kind of wo	al Occupa	ition <i>luring</i> mos	t of worki	ing	16b. Kind	of Business/	Industry	
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2	Hygie ther t	ပိ	17. Father's Name (First, Middle,	Last)			Gen	er ar	парс		er's Name	(First, Middle			CIOH	
7	d be d be d sental d	To Be	Emmett S. Nea								e Dav			,,,,,,,		
2004	shoul nd M mari	۳	19a. Informant's Name/Relation				9b. Mailin	g Address	(Street a	and Numbe	er or Rura	al Route Numb	er, City or T	own, State, 2	Zip Code)	
d ≥	and 2 alth a 27 is		Jeanne O'Neil	L	Frien	d	310	l Riv	er B	end (	Ct. T	Unit Bl	02 L	aurel,	MD 2072	4
T	of He of He		20a. Method of Disposition  T☐Burial 2 ☐ Cremation	2 Domewal	from State	20b. Place ceme	of Dispo	sition (Nar	ne of other place	9)	C	Date	20c. Loca	tion - City or	Town, State	Ti
<u>ئ</u> ر ي	Pag ment ent: b		`4 □Donation 5 □ Other (		- State	Knol1	kreg	Men	noria	l Cer	m. 7,	/15/200	4 Ab.	ingdon	,VA	
July Hy Baltimore	permit. Depart Import any inj		21. Signatule of Funeral Service	Licensee	Ke.	200	D	uda-F	Ruck	s of Facilit Fune:	ral I	Home of	Dunda	alk, I	nc.	
			23a. Part1. Enter the disease, of shock, or he in ailure.	r complications to	hat caused on each lin	the death. D									Approximate Interval Between	
	Physician		Immediate Cause Cause disease or con Mon			Anc	rea	Sit	CH	mo	eR				Month	
	/Medical Examiner		resulting in death)	a Du		consequence				•						
M	Lammer	_	Sequentially list conditions,	b	o to for on		oo of):									
de	ted 1sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	▗	ie to (oi as a	consequenc	ce or):									
_	rate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Du	e to (or as a	consequence	ce of):		<del></del>							
8760	sicial Psicial Puri	lical		d												
(4	rtifical ng phy as th		IF FEMALE:	100												
2	The law requires that the death certificate be the has been signed by the attending physicis age 2 should be detached for use as the but	Physician/Me	23b. Was decedent pregnant in the past 12 months?			of pregnancy 2  Fetal dea		Ectopic p	regnancy				230	I. Date of del Month	ive <i>r</i> y Day Year	
_L_ C	the at	/sici	1 Yes 2 No		Pregnant at Jnknown	time of death	1 5□	Other (sp	pecify)					WOITH	Day Toal	
I o	that the de ed by the detached	P.	Part II. Other significant condit	ions contributing	to death bu	it not resulting	a in the ur	nderlyina a	ause dive	n in Part I		23e. Did t	obacco use	contribute to	the cause of death?	,
2) 6	uires tha signed Id be dei	d by						, ,	ŭ			10	Yes 2∭27	√o 3 🗆 Pr	obably 4 DUnkno	wn
5 3	w requir been si should	lete										24a. Was	an 2	4b. Were au	topsy findings availa	ble
Emme	he tay te has age 2	Completed											osy ormed?	prior to death?	completion of cause of 2□ No	of
I III		e e	25. Was case referred to medical	al						26. Place	of Death	1 Yes	2 No	TUTES	2LI NO	
	g .s Z	To B	examiner? 1 ☐ Yes 2 X No	Hospital:	1  Inpatie	nt 2 EP/	Outpatien	t 3 🗆 DC	Othe	LIFE CONTRACTOR OF THE PARTY OF		me 5 Resi		Other (Spec	city Hospic	ie
1	ding Ph After th funeral		27. Manner of Death  1 ☑ Natural 5 ☐ Pendi	28a. I	Date of Injur (Month, Day	y Year) 28t	b. Time of Injury	2	28c. Injury Work	at		28d. Describe	how injury o	ccurred		
# 3	Attending r death. ector: After by the fune	cati		igation				М	-	/es 2□	-					
Veal	for Att effer d	Certification:		mined 286.	Place of Injubuilding, etc	Iry - At home, :. (Specify)	, farm, str	eet, factory	y, office			28f. Location (a City or Tox	Street and N wn, State)	iumber or Ru	iral Route Number,	
-	To the Hospitel or Attending Ph within 24 hours effer death. To the Funerel Director: Affer th completely filled in by the tuneral	edical C	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physician: T I Examiner: On and	o the best of the basis of manner sta	examination	dge, death and/or inv	occurred estigation	at the tim	e, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) an dato and pla	d manner as ace, and due	stated. to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifi	er 1-	1				c. License						h, Day, Year)	
			V Mindle	my lik	es,	MO		6	)2	520	5		July	,5,0	2004	
	641		30. Name and address of person	who completed	cayse of de			Print)	101	2	2 C	1. Bal	20	11 7	1206	
	ント		W.A.Ri	ley C	-5n		701	N	·C	iail	20 37	· Das	to . 17	10		
	Sta Regista		31. Date filed (Manth, Day, Year	2004	32. Registra	r's Signature	6	Ann	. 10	/						

04 - 4318umpend item#23a,27,28a-f,PER ME,G833,7/27/04eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. B.K.S JOHN T. OREM State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2004 **Physician** JULY 1, 1:15 John Thomas Orem Orem, Sr. Thomas-/Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months tXXM 2□ F 39 14, 1965 Maryland **Director** 215-94-7803 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at Director Glen Burnie Maryland | Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States or items 23s 21061 111 Second Ave. S.E. Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married & Married Baltimore, Maryland 21215-0036 1 Yes 25 No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Building 12 Glazer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary D. Spurrier Daniel Orem, Sr. ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Second Ave. S.E. Glen Burnie, MD 21061 Angelique Orem / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July Date permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2004 Catonsville, MD 4 Donatie 21. Signatur Funeral Sorvice Licensee 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Cocaine Intoxication **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ Completed 24a. Was an page 1 Z Ves 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2□No ٩ 2X ER/Outpatient 3 DOA

the Hospital or Attending Physician: Certification: After death. within 24 hours after death

To the Funeral Director:
completely filled in by the

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 5 € 2 □ No

28a. Date of Injury (Month, Day Year) 7/1/04 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 12:41 unknown 1 ☐ Yes 2X No investigation

6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide residence

111 Second Avenue, S.E., Glen Burnie, MD 🛮 🗀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Treensore 29c. License number 29d. Date signed (Month, Day, Year) JULY 3, 2004 O.C.M.E

РΜ

1 ☐ Yes 2K No

Year

30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medical

2 Accident

(Check only one)

Z Greenberg 37 Registrar's Signature 31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Ma	-	epartmer Certificat				Reg	ne . พู่ผู้. [] []		2127	L	
П	Physici	an	Decedent's Name (First, Middle, Last)		Dowa	ahin			М	ate of Death onth	Day	Year	3. Time of Dea		
5	/Medio		4a. Facility Name (If not institution, give s	Marie Anna street and number)	a Perse		Town, or L	ocation of I		uly 3,	2004 4c. County of	of Death	8:00 F	, IVI	
1	Examir	ier	8300 Bear Creek			,	Dung					timo	re		
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birtho	Months		If Under 24	Hrs. 8. Da	ate of Birth Month, Day, Year)  9. Birthplace (State or Foreign Country)			reign		
	Director		212 20 0,05	M 2₩F	73 Yrs	S.   WOTHER	Luyo		Jai	n. 5,1	931	Mary	lánd		
	land bw		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location						1	0d. Inside City Li	mits	
	Mary I-f sh	tor	Maryland Ba	ltimore				Dur	ndalk				1 ☐ Yes 2 🛭	No	
	th the	Director	10e. Street and Number			10f. Zij	Code			10g	. Citizen of W	hat Cour	ntry?		
	ath wi		8300 Bear Creek						222		United				
	er de:	Funerai		12. Was Decedent E Armed Forces?	ver in U.S.	<ol> <li>Was Dece If Yes, spe</li> </ol>	dent of His cify Cuban,	panic Origir , Mexican, F	n? (Specify Y Puerto Rican,	es or No- , etc.)		- Americ , White,	ean Indian, etc.		
336	urs aff	by F	1 ☐ Never Married 2€ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		1 ☐ Yes	2 <b>√</b> №	Specify:			Specify:		White		
21215-0036	J within 72 hours after death with the Maryland Jiene. I than "natural", or Items 23a or 28a-f show It e Maclical Examirat rust be notified at		15. Decedent's Educ (Specify only highest grade		16a. D	ecedent's Usu	al Occupat	ion	of working	16	b. Kind of Bus				
21	within 7 lene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	ive kind of wo fe. DO NOT u		ning most o	ii working						
121	e filed w Il Hygier other th		12 Years 17. Father's Name (First, Middle, Last)		H	omemake		10 Mothor's	s Nama (Fire)	Middle Ma	Own H				
and	Q 2 0 0	o Be	Edward Lacy					io. Motifer s		Janes		*/			
Maryland	# D E E	To	19a. Informant's Name/Relationship (Ty)	oe, Print Pusa	n 19b. M	lailing Address	(Street an	nd Number	or Rural Rout	te Number, C	ity or Town, S	State, Zip	Code)		
	5 = 0 L		Mr. Joseph A. Pers	eghin, Sr	. 8	300 Bea	ar Cre	eek Di	rive 1	Dunda1	k, Mar	y1an	d 21222	2	
Baltimore,	pes 1 and of Healtl if item 2; or other 1		20a. Method of Disposition 1 ☐ Burial 2▼ Cremation 3 ☐ R	emoval from State	20b. Place of D cemetery,	isposition (Na. crematory or c	me of other place)		Date	20	c. Location - 0	City or To	wn, State		
ţi	ment tant:		`4 ☐ Donation 5 ☐ Other (Specify)		Hillto:				7/6/20	04	Towson	, Ma	ryland		
Bal	permit. Pages 1: Department of He Important: If iten any injury or oth		21. Signature of Funeral Service License	)		Duda-F	uck F	unera	1 Home	of Di	undalk	, Inc			
			23a. Part1. Enter the disease, or compli	cations that caused	the death. Do not							. 23	Approximate		
	Pnysician		Immediate Cause (Final	shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death Onset and Death											
	/Medical Examiner		resulting in death)		consequence of):		_,,,,,	,					6 00	<b>}</b>	
	Examine	_	Sequentially list conditions,		consequence of):							_			
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, bisease of figury	Due to (or as a	consequence on.										
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8760,	ate be hysicia the bur	ledicai	d									Ш			
9	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	/Med	IF FEMALE:	Zo If you sylands											
Вох	attend for us	Physician/M	in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth : 4 ☐ Pregnant at	2 Fetal death	3 ☐Ectopic p					23d. Date Mont		ry Day Year		
o.	at the de by the a	nysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown		0 L 0 tiloi (5)									
٦,	es that igned b be deta	by P	Part II. Other significant conditions con	tributing to death bu	t not resulting in th	e underlying o	ause given	in Part I.	2:	3e. Did tobac	co use contrib	oute to th	e cause of death	?	
Vital Records,	w require been sig should b								-	1 🗌 Yes	2/1000	3 🗌 Prob	ably 4 ∐Unkno	วพก	
ecc	e lawr has be je 2 sh	ompieted							24	ta. Was an autopsy	pr	ior to cor	osy findings availa	able of	
al B	Th ate pag	Con			<u>.</u>				1[	performed Yes 2€		eath?	2 No		
Vit	Physician: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner?	ospital:			Othor		f Death (Che						
of		H- 1	1 ☐ Yes 2 XXIIID	1 Inpatier	28b. Tim		28c. Injury a Work?	4   Nursi			e 6 Dother		′)	_	
<u>io</u>	Attending I r death. ector; After by the funer	atio	1 Accident 5 ☐ Pending investigation	(Month, Day	Year) Inju	M M		s 2 No							
Division	I or Atten after deatl Director; I in by the	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry · At home, farm . (Specify)	, street, factor	, office			cation (Stree ty or Town, S		r or Rura	l Route Number,		
	Hospital	0	29a. Certifier 1 Certifying Phys	icien: To the best o	f my knowledge, d	agth occurred	at the time	date and r	place, and du	o to the caus	o/s) and man	nor 25 5t	atod		
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical Examinate)	ner: On the basis of and manner sta	examination and/o	r investigation	, in my opir	nion, death	occurred at the	he time, date	and place, ar	nd due to	the cause(s)		
	To the within To the Comp	ž	29b. Signature and title of certifier			29	. License r				Date signed	(Month, I	Day, Year)		
			, which	m0			De	4460	t		1214				
	6		1.	mpleted cause of de	ath (Item 23a) (Ty		-1	0	A		2045		2123	L	
	Sta	te	31. Date filed (Month, Day, Year)  JUL 0 7 2004		r's Signature	DI-CI +	7	13	JELING	DEE	MO		2123		
	Registr		JUL 07 2004	Serve	1	Span	21								

		Please Type or Print in Black II  State of Maryland / Dep	ndelible Ink. Ensure Al partment of Health and M	-	
	•	1 - State Registrar Co	ertificate of Death	Reg.	No2004 21275
Physici	ian	1. Decedent's Name (First, Middle, Last)		<ol><li>Date of Death Month</li></ol>	Day Year 3. Time of Death
/Medi	cal	Elena I. Pertetto		July ,	2 2004 8:40P. M
Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	'	4c. County of Death
Funeval		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	BALTIMORE  y) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign
Funeral Director		037.05-2384 10M 201F 96 Yrs.	Months Days Hours Min.	(Month, Day, Ye	Par) Rhude Island
pu >		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or	Location		10d. Inside City Limits
/anyla	5	ma lo :	wherville		1 ☐ Yes 2 12/No
the A	rect	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country?
3a or	<u> </u>	17 Brookstone Ct.	21093		1)SA
deat	Funeral Director		B. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
s after , or It		1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2月 No Specify:		Specify: 1 h . to
ture i	Completed by		edent's Usual Occupation	161	b. Kind of Business/Industry
Z15-UU36 thin 72 hours aff e. en "naturel", or Medical Exam	plet	(Specify only highest grade completed) (Gill Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of worki . DO NOT use retired)	ng	
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<b>_</b> \$ <u>a</u> a <u>a</u> a <u>a</u> a <u>a</u> a <u>a</u>	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Mai	iden Sumame)
ryian	ို	Aiello Strum 0/0	iling Address (Street and Number or Rura		LSTARA
Mar d 2 sh th and th and treum	1	19a. Informant's Name/Relationship (Type, Print)  19b. Ma  Claine Smith-daughter  17	Arra VS + n a C4	Liberay 11	0 M D 71092
re, M s 1 and 2 f Health liem 27 other tr		20a. Method of Disposition 20b. Place of Dis	position (Name of ematory or other place)	Date 200	c. Location - City or Town, State
Pages nent of ont: If it		1 Burial 2 Cremation 3 Hemoval from State	5 Comokry 17-15	1-04 C	ansten RI
alti mit. mit. porte y injt		21. Signature of Funeral Service Licensee	22. Name and Address of Facility RD		um. mo 21093
<b>n</b> 82588			LACEFUL ALTERNATI	ICS FUNE	RAC-CREMATION CIT
		23a. Part1. Enter the disease. a pmplications that caused the death. Do not e shock, or heart failure. List only the cause on each line.	inter the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	enertia:		
Examiner		Due to (or as a consequence of):	elar Disease		
	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events			
60, be executed siclan and burial-transit	Examiner	Cause (Disease or in Ut) that initiated events c.			
760, e be exe siclan a s burial-	al Ex	resulting in death) Last Due to (or as a consequence of):			
687 tificate t tig physical as the t		d	· · · · · · · · · · · · · · · · · · ·		
ds, P.O. Box 687  uires that the death certificate signed by the attending physical doe detached for use as the	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
Geathe	icla	in the past 12 months?  1  Yes 2 No	B□Ectopic pregnancy  □ Other (specify)		Month Day Year
P.O. BOX at the death cer by the attendin stached for use	hys	9 🗆 Unknown		00. Bidasha	and the second s
S the signed be de	þ	Part II. Other significant conditions contributing to death but not resulting in the	heart Failne,		co use contribute to the cause of death?  2 \( \text{No} \) 3 \( \text{Probably} \) 4 \( \text{QUnknown} \)
Cord: w require been signshould to	eted	119po 1yoursm, 110 corpsine			
Hec elaw has t	Completed	1H2) hutis		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
n: Th		25. Was case referred to medical	25. Blace of Death	1 Yes 2	
Vil /sicie s certi	To Be	examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 EP/Outpat	Other #		e 6 Other (Specify)
Division of Vital Records, to a tending Physicien: The law requires thater death. Director: After this certificate has been signed in by the funeral director, page 2 should be considered.		27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how	
endin eath. or: Af	catic	2 Accident investigation	M 1 Tyes 2 No		
or Att frer de direct	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
pitel ours at ours at ours at ours at ours at our ours at our ours at our ours at our ours at our ours at our ours at our ours.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place	and due to the caus	se(s) and manner as stated
24 hos 24 hos Fun etely (	Medical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or and manner stated.			
Division of Vital Records, P.O. Box 687 To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
		P.T. Fiberts, Ms.	D21464		7/7/04
10		30. Name and address of person who completed cause of death (Item 23a) (Typ		4. 4	(1)
Ψ	1	ROBERT LIBERTO, MD. 3508 Ba	ul ST BAZTU,	pre 2	-1224
St Regist	ate trar	JUL 07 2004			
DHMH 17 Rev 1/2		20 BQT LIBGOZD, MD 3508 Ba 31. Date filed (Month, Day, Year)  32. Registrar's Signature  34. Date filed (Month, Day, Year)  35. Registrar's Signature	Sparks		
		ORIGIN			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Marilyn Mae Pappas July 3, 2004 3:35A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 11750 Old Georgetown Road, #2213 North Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Jan. 6, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 ☐ M 2 🗓 F California 569-42-4243 69 ์ไฮ๊35 Director Usual Residence of Decedent daath with the Maryland 10a State 10c City Town or Location 10d. Inside City Limits 10h County itam 27 is marked other than "natural", or itama 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☑ No North Bethesda Directo Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11750 Old Georgetown Road #2213 20852 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pagas 1 and 2 should be filled within 72 hours aftar d Dapartment of Hasilh and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or itam any injury or other traumatic event, the Words Exercited Presented. Black, White, etc. 1 ☐ Yes 2 ⊠ No 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes Give þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Joseph McCourt Helen Reba McAlpine ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Pappas/Daughter 18028 Rockingham Place, Germantown, Maryland 20874 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven Date 20c. Location - City or Town, State 20a. Method of Disposition July 8, 1 ⊠Burial 2 □ Cremation 3 □ Removal from State ^ 4 □ Donation 5 □ Other (Specify) 2004 Silver Spring, Maryland Cemetery 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Serfice Licensee Yo M00198 300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Months Esophageal Cancer resulting in death) /Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to many cause. Enter Underlying Cause (Disease or injury Dira to (or as a nonsequence of) Examine attanding physician and for usa as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☑ No signad by tha 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by ed bluods 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown baan 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificate 1 Yes 2 No 1 ☐ Yes 2 🔀 No or Attanding Physician: diractor. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) ٩ 1 Tes 2 No Aftar this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pendina after daath.

I Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a fillad To the Hospital 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical complately (Check only one) 29b. Signature and title of cerylier 29c. License number 29d. Date signed (Month, Day, Year) D0057475 7-3-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ari D. Fishman, M.D. 5480 Wisconsin Avenue, Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUL 07 2004

**ORIGINAL** 

& Sports

			For State Registrar	State of	Marylan		artmen			and Me		giene	nnl	21277
			Decedent's Name (First, Middle,	Last)						2	. Date of Dea		<del>9 0 7</del>	3. Time of Death
	Physici	an	David	Otha1		D-11	ker			т.	Month	Day	Year 2004	6.EED M
1	/Medic		4a. Facility Name (If not institution,			KTI		Town or	Location of		uly		2004 ounty of Deat	6:55P M
1	Examin	ier		-	01)									
			Holy Cross Hos  5. Social Security Number		Ane (In vrs	last birthday)	If Under	ilve:	If Under	ring	. Date of Birt	h	1tgome	
	Funeral Director		379-44-4152	1⊠M 2□F	Ago (III )13.	Yrs.	Months	Days	Hours	Min.	(Month, Day	Year)	Mich	hplace (State or Foreign untry) 11gan
			Usual Residence of Decedent							114	ау т,	1747	riici	115411
	land	1	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Mary fied	ğ	Maryland   Prince	George's	Re	ltsvil	le.							1 ☐ Yes 2X No
	the 28a	Director	10e. Street and Number	deorge b		TCD V XX	10f. Zip	Code				10g. Citize	n of What Co	ountry?
	with with		11340 Evans Tra	<b>11</b> T_2				705				Unita	ed Stai	tos
	eath	Funeral	11. Marital Status	12. Was Decede	ent Ever in U	.S. 13.			spanic Orie	gin? (Specif	fy Yes or No-		. Race - Ame	
	lten lten	ä	1 Never Married 2 Marrie	Armed Forc	es?	.0.	If Yes, spec	rfy Cubai	n, Mexican	, Puerto Rio	can, etc.)		Black, White	e, etc.
36	I', or	by	3 Widowed 4 Divorced	If Yes, Give Year or Date			1 ☐ Yes	2⊠ No	Specify:			S	pecify: Wh	nite
ş	72 hours atter death with the Maryland natural; or Items 23a or 28a-1 show Jisal Examinat must be molified at		15. Decedent			16a. Dece	dent's Usua	I Occupa	ation			16b. Kind	of Business/	Industry
15	in 72 n "ne finetiv	plet	(Specify only highest	grade completed)	5 )	(Give	kind of wor DO NOT us	rk done d se retired,	luring most )	t of working	1			•
7	I within iene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4	OI 3+)	Compu	ter S	yste	ms Sp	ecial	ist	Priv	vate C	ontractor
g	be filed within 72 hours after death with the Marylan ital Hygiene.  ad other than "natural", or Items 23a or 28a-1 show od other than "natural", or Items 23a or 28a-1 show event, the Medical Examiner must be notified at	BeC	17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name (F	First, Middle,	Maiden Su	ımame)	
Maryland 21215-0036	should be and Mental s marked o umatic eve	ToB	Othal  19a. Informant's Name/Relationsh		Riker	405 44-00		(0)1		tta	3- 4- 1/		Langwor	<del>_</del>
	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		Anthony D. Rike								Route Numbe t ∦B;			7A 22315
Baltimore,	Pages 1 and of Height of H		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation	3 □Removal from St	ate (	Place of Dispo cemetery, crea	natory or o	ther place		Dat			tion - City or	
Ħ.	tmen tant:		`4 □Donation 5 □ Other (Sp		Rose	edale Me	-			/10/2	004	Grand	l Rapid	ds, MI
Bal	permit. Pages. Department of H Important: If Ite any injury or of once.		21. Signature of Funeral Service L	1-1	100986	]	Name an Rapp 933 G	Fune: ist	ral A Avenu	nd Cr e Sil	ematio ver Sp	n Ser	vices MD 20	910
		23d. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest speck, or heart failure. List only one cause on each line.												Approximate Interval Between
	Physician		Immediate Cause (Final	·	rt Fai	luro								Onset and Death
7	/Medical Examiner		disease or condition resulting in death)	a	asaconsec									48 Hour
				Myo	cardia	1 Infa	rctio	n						
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consec	quence of):								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury) that initiated events	Core	onary .	Athero	scler	osis						
Ć	exection and an and rial-tr	Еха	resulting in death) Last	Due to (or	as a consec	quence of):								
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9	g phy as th	ed												
Вох	eath certitic attending p tor use as f	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		∃Ectopic pr					230	d. Date of del	ivery
m.	death e atte	lc la	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnar	nt at time of o		Other (sp						Month	Day Year
0	t the de by the tached	hys	9 🗆 Unknown	9∐ Unknow	m									· · · · · · · · · · · · · · · · · · ·
σ,	s thai	by P	Part II. Dther significant conditio	ns contributing to dea	th but not res	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
rd	quires n sign uld be		Diabetes								1 🗆 Y	'es 2 □ !	No 3□Pr	obably 4 XUnknown
Vital Records,	law requires that the as been signed by th 2 should be detache	Completed									24a. Was		24b. Were au	topsy findings available
Re	0 - 0	шс			-			-				rmed?	death?	completion of cause of
a		Ö	25. Was case referred to medical						26 Place	of Death (	1 ☐ Yes Check only o	2 No	1 🗆 Yes	2 No
		OB	examiner? 1 ☐ Yes 2 🖾 No	Hospital:	nationt 2	ER/Outpatier	nt 3 DC	A Othe			5 ☐ Resid		Other (Spe	Cific)
of	ig Physter this neral di	-	27. Manner of Death	28a. Date of (Month,		28b. Time o		8c. Injury Work			d. Describe h			51177
lon	불문절	tloi	1 XNatural 5 ☐ Pending 2 ☐ Accident investig	,	Day Year)	Injury	м		<br Yes 2 🔲 I	No				
Division	or Attending atter death. Director: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place o		ome, farm, st	reet, factory	, office		281	f. Location (S	Street and I	Number or Ru	ıral Route Number,
Ö	2 9 5 2	Certification;	4 🗆 Hollicide	Bullaing	, etc. (Speci	iy)					City or Tow	ni, Siaie)		
	To the Hospital of within 24 hours along the Funeral Discompletely tilled it	edical	29a. Certifier 1 X Certifyin (Check only one)	Physician: To the bear examiner: On the bas and manner	is of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my or	ne, date an pinion, dea	d place, and th occurred	d due to the o at the time, o	cause(s) ar dato and pl	nd manner as ace, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier				290	. License	number			29d. Date s	signed (Monti	h, Day, Year)
	->-0		A /	1. Pie	1- 1			D2	3805			July	4, 20	04
	17		30. Name and address of person	vho completed cause	of death (Ite	m 23a) (Tyne	Print)							
	10		Daniel Woronow			al Par		ve S	ilver	Spri	ing, M	209	902	
	Sta		31. Date filed (Month, Day, Year)	32. Res	gistrar's Sign	ature								
	Regist	rar	JUL 0 7 201	14 Garle	رمس	B,	Loon	65						

			for State Registrar	State of N	/laryland / (	Departmen <i>Certificat</i>				giene	21278	
	°Physici	an	1. Decedent's Name (First, Mid Marv Petti			ogiator.			2. Date of De	7, Day Yea 7, 2004	3. Time of Death	
1	/Medic		Mary Pett1  4a. Fecility Name (If not institut			Register 4b. City,	Town, or Loc	cation of Death		4c. County of De	1:30 A M	
15 60	EXAMINI	(F)	Friends Nursi				ndy Sp			Montgo		
ř	Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. last bii	Months		Under 24 Hrs. lours Min.	8. Date of Birt (Month, Da	h 9. B	irthplace (State or Foreign Country)	
	Director		231-88-7825 Usual Residence of Decedent	1	93	Yrs.			Aug. 2	5, 1910 So	uth Carolina	
	hours after death with the Maryland turel', or Items 23s or 28e-f show Efertiret must be rolliked at	ctor	10a. State 10b. Coun	nty tgomery	10c. City, Tow Sandy						10d. Inside City Limits 1 ☐ Yes 2X No	
	or 28	Director	10e. Street and Number			10f. Zip				10g. Citizen of What	Country?	
	s 23c	eral	17401 Norwood		at Ever in II C	208		nin Onining (Co	acifu Vac ar Na	United Sta		
920	2 hours after death with the Marylan eturel; or Items 23s or 28e-f show cell Evaninar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ M.  3 ☑ Widowed 4 □ Divorce	Armed Forces 1 ☐ Yes 2 ₹ If Yes, Give	1 ☐ Yes 2 X No			Mexican, Puerto	pecify Yes or No Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.  Specify: White		
2-0	OI 00 68	Completed	15. Deced	lent's Education hest grade completed)	16a	Decedent's Usua (Give kind of wo	al Occupation	n na most of work	kina	16b. Kind of Busines		
21	d within 7% giene. ir then "ne Ir e Medii	mple	Elementary/Secondary (0-12		r 5+)	life. DO NOT us	se retired)		ung	. ·		
2	77 75 15 100		17. Father's Name (First, Middle			Piano In			ne (First Middle	Music  Maiden Sumame)		
Maryland 21215-0036	be de la la la la la la la la la la la la la	To Be	Thomas Oswald	Lee				Mary E	leanor			
Mai	s 1 and 2 should f Health and Mer item 27 Is marke other treumetic		19a. Informant's Name/Relatio James H. Regi			5. Mailing Address 407 B We				er, City or Town, State NC 28328		
Baltimore,	0 0		20a. Method of Disposition  1 X Burial 2 Crematio  4 Donation 5 Other	on 3 Removal from Stat	20b. Place o	of Disposition (Namery, crematory or o	ne of ther place)		Date	20c. Location - City of Clinton,		
Baltir	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service	H 2 - 2		Royal-	d Address of Hall F	Facility uneral	Home, I	nc.	NO	
	Physician /Medical Examiner	er	23a. Part I. Enter the Useas	b	Bye Cuas a consequence	of):		uch as cardiac			Approximate Interval Between Onset and Death	
Box 68760,	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medical Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	d		,				23d. Date of d	elivery	
P.O. B	at the death by the atte	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death at time of death	n 3 □Ectopic pr 5 □ Other <i>(sp</i>			- SW	Month	Day Year	
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant cond	litions contributing to death	but not resulting i	in the underlying c	ause given in	Part I.	23e. Did to	_	to the cause of death?  Probably 4 Minknown	
Vital Records,	The ate h page	Completed								an 24b. Were street 24b. Were prior to death?		
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medi examiner?	Hospital:			Othor		th (Check only o			
of		T: To	1 ☐ Yes 2X No 27. Manner of Death	28a. Date of Ir	jury 28b.	Time of 2	8c. Injury at Work?	4 X Nursing Ho		lence 6 Other (Sp.	pecify)	
Division	l or Attending latter death. Director: After	Certification:	3 Suicide 6 □ Cou	estigation and the seminary 28e. Place of I	njury - At home, fa etc. (Specify)	М	1 🗌 Yes	2 □No	28f. Location (S City or Ton	Street and Number or I	Rural Route Number,	
	Hospite 4 hours 7 unerel rely filled	edical Ce	29a. Certifier 1  Certification (Check only one)	lying Physician: To the best cal Examiner: On the basis and manner	of examination ar	e, death occurred nd/or investigation	at the time, o	date and place, on, death occur	and due to the o	cause(s) and manner adate and place, and di	as stated. ue to the cause(s)	
	To the within 2 To the complet	Mec	29b. Signature and title of certi		-tatog.	290	. License nu	mber		29d. Date signed (Moi	nth, Day, Year)	
			Kshan		MD		060	826		6/28/0	4	
	7		30. Name and address of personal Shama	rara, M.D.	18111	Prince 1	Philip	, D, #	328 (	3 lney, N	10 20832	
	Sta Registi		31. Date filed (Month, Day, Yell JUL_0 7 2)		strar's Signature	1	1 4			•		

DHMH 17 Rev 1/2001

ORIGINAL

		•	State of Maryland / Department of Health and I 1- State Registrar AMEND ITEM #1 PER PHY G833 Certificate of Death		ene .m2.004 21279	
	Physici		1. Decedent's Name (First, Middle, Last) ALFONSO ENRIQUE RODRIGUEZ Alfonso Enrique Rogriguez	2. Date of Death	3. Time of Death 9:00 р м	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  16 Forest Drive  Bel Air	h	4c. County of Death Harford	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 68 7. Age (In yrs. last birthday) Yrs.  1 M Online Days Hours Min.	B. Date of Birth (Month, Day, Y February 27	(ear) 9. Birthplace (State or Foreign Country) Puerto Rico	
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location Bel Air		10d. Inside City Limits 1 ☐ Yes 2 🕅 No	
	h with the 23a or 28a	al Director	10e. Street and Number 16 Forest Drive 110f. Zip Code 21014	1	J. Citizen of What Country? USA	
936	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, its Medical Esoninst invalue and the notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Nidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No 53-162 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl Yes, Give Year or Dates:	o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
21215-0036	within 72 horens	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementacy/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5)  College (1-4or 5)  College (1-4or 5)	rking 16	b. Kind of Business/Industry  General Motors	
	2 should be filed with and Mental Hygiene. Is marked other that raumatic event, ILE IN	To Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name Francisc  18. Mother's Name Francisc  18. Mother's Name Francisc	me (First, Middle, Ma	iden Sumame) Arizarry	
2	and 2 shou ealth and M n 27 Is mar		19a. Informant's Name/Relationship (Type, Print)  LuCena Rodriguez-wife  19b. Mailing Address (Street and Number or Ru 16 Forest Drive, Bel Air		City or Town, State, Zip Code)	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, II as Ing. Once.		20a. Method of Disposition  1 28 Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Dulaney Valley Mem 1 Gard. July	Date 20 7, 20(4T	c. Location - City or Town, State imonium, MD	
Balt			21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Let 5305 Harford Rd., Ba	ltimore, MD	21214	
8760,	The law requires that the death certificate be executed and also has been signed by the attending physician and angle 2 should be detached for use as the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):		Onset and Death	
P.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year	
	w requires that i been signed by should be deta	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cause of death?	
al Records,	: The law requ cate has been , page 2 shoult	Completed by		24a. Was an autopsy performa 1 Yes 2		
of Vital	Physician: The this certificate ral director, pag	To Be	examiner? 1   Yes 2   No		ce 6 □Other (Specify)	
Division o	ling After fune	Certification:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident 3 Suicide 6 Could not be determined  28a. Date of Injury 28b. Time of Injury Work?  M 1 Yes 2 No  28b. Place of Injury - At home, farm, street, factory, office		et and Number or Rural Route Number,	
Ω	To the Hospital or Attent within 24 h. urs after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only  29a Certifier (Check only  29a Certifier (Check only  29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place		se(s) and manner as stated.	
	To the within 2. To the i	Medical	one) and manner stated.  29b. Signature and title of certifier 29c. License number		. Date signed (Month, Day, Year)	
	L.I		30, Name and address of person who completed cause of death (Item 23a) (Type, Print)		67-06-04,	
10	11		Frank Palmisano, M.D. 5122 Harford., Baltimore, MD 21214			
	Sta Registi		JUL 0 7 2004  32. Registrar's Signature			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registres Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** KAMSBURG 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ARK 6. Sex VENUE TIMORE 1 Year Trunder 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Min Hours 217-26-119 1□ M 2 F Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County or 28a-1 show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hyglene.
anit: if item 2 7 is marked other than "natural", or items 23a or 28a-1 show anit: it item 2 7 is marked other than "natural", or items 23a to 128a-1 show any or other traumatic event, it is Macing Examplest and be recilled at 1 Yes 2 □ No ALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number WESTFIELD Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) ARRIGO ORNELL E SSE ၉ 19a. Informant's Name/Relationship (Type, Print) + SPAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 21214 ARENCE WESTFIEL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Kark 7-9-04 Moreland Mem. PARKVILLE MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility EVANS HAPEL OF MEMORIES 21. Signature of Funeral Service Licenses 8800 HARFORD PARKVILLE, MD 2123 RD. aya Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head bailure. List only one cause on each line. Immediate Cause (Final Physician Glomus Tumor of disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) ending physician are use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4 Pregnant at time of death 5 ☐ Other (specify) P.O. I ed by the a detached f 9 Unknown cate has been signed l page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ρ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an The law autopsy 2 **X** No certificate 1 ☐ Yes Vital Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) DAUGH TERIS Hospital: 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Cher (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To RESIDENCE of this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Division Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 🗆 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npletely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 D44271 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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32. Registrar's ignature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death RACHUBA **Physician** FILEEN 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE PARKVILL OAKDALE AVENUE If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 214-22-1428 1 □ M 2 SF Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28e-f shov other treumetic event, the Medical Examiner must be notified at U ARYLAND PARKVILLE 1 ☐ Yes 2 XNo Director JALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 9644 21234 SA AVENUE MAKDALE Items 23e Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "naturel", or Iter 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be Mc ALICE PARTLAND ENNEDY MHOI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HUSBAND permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tree 9644 PARKVILLE MD 2123 OSEPH OAKDALE AVE. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ODCEMETERY JULY 7, 2004 PARKVILLE, MARYLAN 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES PARKWOOD PARKVILLE, MARYLAND \* 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee al HARFORD RD, PARKVILLE, MD 23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate / Interval Between Onset and Death Immediate Cause (Final Physician POORLY CIFFERENTIATED MUTASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): CARCINUMA OF UMKNOWN PRIMARY **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certiticate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an deenbit certilicate has autopsy 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No Certification: To this tilled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Alter 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. 2 Accident investigation 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) molhyem Phyncian 1) 0052292 J 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINDHU JAMES MD, 1447 YORK ROAD , Cultirolle mo

State Registrar 31. Date filed (Month, Day, Year)

JUL 0 7 2004

32. Registrar's Signature

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**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Margaret Jean Roe Ju1y 6, 2004 4:00 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Bedford Court Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 18, 1920 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 1 1 F Illinois 84 Director 348-03-1677 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County rthan "natural", or Items 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural; or items 23a any injury or other traumatic evant, the Mantan 3700 International Drive United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Public Schools School Auditor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Verna Beckett George Ringness 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14601 Dodie Terrace, Darnestown, Maryland 20878 Daniel M. Roe/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Montgomery Crematorium Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 21. Signature of Funeral Service Licensee M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Years Physician Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs Listage of Figure Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Causa (Disease of I resulting in death) Last physician ar s the burial-t Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 ☐ Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan has le 2 autopsy performed? page certificate 2X No 1 ☐ Yes Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner Hospital: 1 ☐ Inpatient Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 Tes 2 X No 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending after death. 1 Tyes investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) lin by 4 Homicide within 24 hours a To the Funaral D 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) sal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated tha 29c. License number 29d. Date signed (Month, Day, Year), 29b. Signa ture 9 D38457 30. Name and ordress of person who completed ause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 Nakul Goyal, M.D.

2004

Box 68760.

2. Registrar's Signature

3801 International Drive, Silver Spring, Maryland 20906

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1605 200 Y /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore If Under 1 Year | If Under 24 Hrs. last birthday) Birthplace (State or Foreig Country) **Funeral** Days Months 1**№** M 2□ F Yrs. Director the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Medical Exercit ar most be notified at 1 XYes 2 □ No Director TIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral Was Decedent Ev Armed Forces? 1 Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within and Mental Hygiene. ondary (0-12) College (1-4or 5+) (First, Middle, Last) ame (First, Middle, Maiden Sumame) 19b. Mailing Address (Street ar s 1 and 2 s of Health an item 27 is 20a. Method of Dispos permit. Pages 1
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any injury or oth 1 K Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalure 23a. Part1. Enter the disease, shock, or heart failure. L ath. Do not enter the Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Examiner dany leading to immodit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed undrome 1 Yes 2 No To the Hospitel or Attanding Physician: 25. Was case ref-rred to medical examiner? Be 26. Place of Death Check onl one 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient this 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After t 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 1 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUKKAR, A DLAH Wolfe St HOSPITA 600 N The Johns Hookins 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

JUL 07 2004

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death WILLIAM CLARENCE 1004 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death ALTIMORE REHABILITATION EXTENDED 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign 1**X**M 2□F idence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Zeyes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. orces? 1 Never Married 2 Married 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working plife. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 19b. Mailing Address (Street and 20a. Method of Disposition Burial 2 □ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each the death. Do not enter Interval Between Onset and Death Immediate Cause (Final ENCEPHALO disease or condition resulting in death) months WIRED IMMUNE DEFICIENCY Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

Priysician /Medical Examiner

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attending physician

Box 68760

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Division of Vital

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Examiner

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Certification:

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**Physician** 

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**Funeral Director** 

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**Funeral** 

Director

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death with the Maryland

filed within 72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene ent: If item 27 is marked other then '

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant

Physician/Medlcal ģ

autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

2 No Yes

2 🗌 No

26. Place of Death Check only one)

28d. Describe how injury occurred

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

25. Was case referred to medical examiner? Other: 1 ☐ Yes 2 📉 No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

AURORA

1 Natural

2 Accident

3 Suicide

4 Thomicide

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

Me

32/Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH

State Registrar

			For State Registrar	State of Ma	aryland /		artment o				F	Reg. No.	004	21285	
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ath wi	s 23a		3912 WYATT			1.0.1		120		2.10			USA		
C 21215-0036 filed within 72 hours after death with the Maryland	"natural", or items 23a or 28a-f show edical Examiner must be mutilised at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ I If Yes, Give X Year or Dates:			was Deceden f Yes, specify I □ Yes &		panic Orig , Mexican, Specify:	in? (Spec , Puerto F	cify Yes or No- Rican, etc.)		Race - Americ Black, White,		
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Baltimore,	r oth		20a. Method of Disposition  Disposition  Greenation 3 □  Other (Specify	Removal from State	20b. Place o	of Dispo	sition (Name natory or othe WN CE)	of or place,	)		ate	20c. Loca	tion - City or To	own, State	
			21. Signature of Fone al Service Licen				FSTE						E P.A. D. 212		
113	100		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused one cause in each lin	the death. Do					cardiac or	respiratory arr	est.	). ZIZ	Approximate Interval Between	
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p <sub>0</sub>	sit	lner													
60, be executed	sician and burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):				· · · · · ·					
ate	the sh	dlcal	(												
Hecords, P.O. Box 61 The law requires that the death certific	by the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknow								23d. Date of delivery Month Day Year				
rds, P	n signed b	b	Part II, Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.									co use contribute to the cause of death?			
VITAL RECORDS, icien: The law requires t	page 2 should I	Completed									24a. Was a autop: perfor	sy	24b. Were auto prior to cor death? 1 \( \text{Yes}	psy findings available inpletion of cause of	
VITA icien:	certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:						of Death	(Check only or				
OT Shys	er this eral dir	n; To	27. Manager of Death	28a. Date of Inju	y 28b.	Time of		Other Injury a	at INUI		le 5 ☐ Resid 8d. Describe h		Other (Specif)	/)	
SION	death. ctor: After y the funer	catio	1 Natural 5 Pending investigation		/ Year)	Injury	М	Work? 1 □ Ye	es 2□N	lo					
DIVISION Ital or Attanding	rs after d rel Direct led in by I	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	building, et	c. (Specify)						City or Tow	n, State)		l Route Number,	
DIVISION OF VITA To the Hospital or Attanding Physicien:	within 24 hours after deatl To the Funerel Director: completely filled in by the	fedical	(Check only one)	ysician: To the best niner: On the basis of and manner sta	examination a	je, death nd/or inv	estigation, in	my opir	nion, death	l place, ar h occurre	d at the time, d	ate and pl	ace, and due to	the cause(s)	
To	Twith Con	Σ	29b. Signature and title of centiles	Mis M	0		29c. L		number 145	01			igned (Month,	2004	
	H		30. Name and addr ss of per on the contract of	7-111 N7 12	130	T	MIN	-	_ ^	100	HC				
	Sta	-	31. Date filed (Month, Day, Year)	32. Registr	r's Signature										
DUA	Registr	ar	JUL Q 7 2004	Bereve	D,	Spo	uls								

ORIGINAL

			For State Registrar	State of	Maryland /	•	artmen				lental Hy	giene	100	s. 2	128	36
			Decedent's Name (First, Midd	le, Last)							2. Date of De	eath	-		Time of D	eath
	Physici /Medio			Marie	Mildred	st	rasba	ugh			July 2	, 20	04	ear 7	:12 F	M A
	Examir		4a. Facility Name (If not institution	n, give street and num	ber)		4b. City,	Town, or	Location	of Death		4c.	County of	Death		
			Johns Hopkins						re C	-			N/			
	Funeral Director		5. Social Security Number 213-20-3657	6. Sex 1 ☐ M 2 🖾 F	'. Age (In yrs. last b	irthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bi (Month, Di Oct. 8			Birthplace Country) Iest V		
	land		Usual Residence of Decedent  10a. State 10b. County	,	10c. City, Tov	wn or Lo	cation							10d. I	nside City	Limits
	Many -f sh	ţō	Maryland	Baltimore	2			Edge	emere					1	I □ Yes 2	2 X No
	r 28e	Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of Wha	at Country?		
	th with	aiD	7419 Blevins	Avenue					212	19		Unit	ed St	ates		
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: If item 27 is marked other than "natural", or items 23a or 28e-f show appropriate if item 23a or 28e-f show any injury or other traumetic event, the Medical Eventral matter mail by Indifficat at ance.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Mai  3 ※ Widowed 4 □ Divorced	ried 1 Tes	⊋ <mark>⊊</mark> No		Was Deced f Yes, spec 1 ☐ Yes		ispanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)	0-	Black, \ Specify:	American Ir White, etc. Thite	ndian,	
9	2 hou	ted	15. Deceder	nt's Education	168	a. Deced	dent's Usua	I Occupa	ation			16b. K	ind of Busin		у	
215	within 7. ene. than "n	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-	4or 5+)	(Give life. I	kind of wo DO NOT us	ik done d se retired	during mos )	it of work	ing					
21	ad wit	20 To		2 Yea			Nurse	<u>.                                    </u>					rankl	in Sq	uare	Hosp
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle,								(First, Middle		Surname)			
yla	Ment Ment arke	2		rvin Plume	77-						F. Pric	-				
Maryland	and 2 should be filed within 'salth and Mental Hygiene. n 27 is marked other than "er traumetic event, the Meg		19a. Informant's Name/Relations Mr.Samuel F.				-				ward, Numb				le)	
ē,	s 1 al f Hea item othe		20a. Method of Disposition	_	20b. Place o	of Dispo	sition (Nan	ne of ther place	e)		Date	20c. Lo	ocation - Cit	y or Town,	State	
Ë	Page nent o int: If iry or		P⊠Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (\$		tate !	-	Ceme			/200	4	Ва	ltimo	re,	Mary	1and
Baltimore,	permit. Departn importa any inju		21. Signature of Funeral Service	Licensee Ma A	seel						Home of					
			23a. Part1. Enter tile disease, o	r complications that ca	used the death. Do						ndalk , or respiratory a		Tand	2122 App	roximate	in 1
	Physician		shock, or heart failure. Lis Immediate Cause (Final disease or condition	t only one cause on ea	7 or ti	<u>_</u>	57	ten	205	is					erval Between and De	
	/Medical Examiner		resulting in death)	Due to (c	r as a consequence	of):										
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (a	r as a consequence	of):										
	outed od ransit	Examiner	that initiated events	C												
oʻ	cate be executed by sician and the burial-transit	Ex	resulting in death) Last		r as a consequence	of):										
8760,	ate be hysici the bu	lical		d												
.O. Box 68	The taw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	ic pregnancy r (specify)					23d. Date of delivery Month Day Year							
Δ.	that the by detail	V Ph	Part II. Other significant conditi	ons contributing to dea	ath but not resulting	in the ur	nderlying c	ause give	n in Part I	÷	23e. Did	tobacco u	ıse contribu	te to the ca	use of dea	ath?
ecords,	w requires been sign should be	ted by		· •					_		10	Yes 2	No 3[	Probably	4 □Uni	known
$\alpha$		Completed									24a. Was auto perfo 1 Yes		24b. Wer prior deat 1 🗆		tion of cau	railable ise of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medica examiner?	Hospital:				Othe			(Check only					-
of	Phy this ral d	. To	1 ☐ Yes 2 No  27. Manner of Death	1 110	patient 2 ER/O	utpatien Time of		Bc. Injury	at		me 5 Resi			Specify)		
on	ding Phy th. : After thi funeral o	tion	1 Natural 5 Pendi	ng 28a. Date of (Month)	, Day Year)	Injury	М	Work	(? Yes 2.⊟:				,			
Division	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Certification;	3 Suicide 6 Could 4 Homicide deterr	not be 28e. Place of	of Injury - At home, f g, etc. <i>(Specify)</i>	arm, str	eet, factory	, office			28f. Location ( City or To			or Rural Rou	ıte Numbe	ər,
1	fospitel t hours uneral		29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To the t Examiner: On the ba	pest of my knowledg	e, death	occurred	at the tim	e, date an	d place,	and due to the	cause(s)	and manne	or as stated.	cause(s)	
	o the Prithin 24 o the Promplete	Medical	one) 29b. Signature and title of certifie	and manne	er stated.		290	. License	number			29d. Dat	e signed (M	fonth, Day,	Year)	
	F ≤ F δ		· AC. D.	170 12.	29 11	1	7	)4	605	32		7	121	200	4	
	0		30. Name and address of person	who completed cause	of death (Item 23a)	(Туре,	Print)	NE	ET	24 )	DESA	1019	WAF	- M	1	
	2		1101 11111	E- 1. 1011 1	QUARE	1	RIVE	· B	ALT	TIM	ORE,	MI	) 2	123	7	•
	Sta Registr		31. Date filed (Month, Day, Year	) 32. Re	gistrar's Signature	4	has	./			111					

			1100001	State of Maryla	nd / Dona	rtmoi	t of Woolf	h and M	Mental Hy	niana	_09.2.0.	
			1 - For State Registrar	State of Maryla	•		te of Dea			Reg. Ng:	1000	21287
	* 3×4		Decedent's Name (First, Middle, Last)						2. Date of De	ath		3. Time of Death
	Physicia /Medic		ANNETTA		OKU:		T	15	Month 06	Day	7 200 County of Dea	
	Examin	er	4a, Fecility Name (If not institution, give s ROCK SPRING VIL	LAGE I COL	GATE DA		Town, or Local			)	HARF	
	Funeral Director		5. Social Security Number 6. Sex		. last birthday) Yrs.	If Unde Months		nder 24 Hrs. urs Min.	8. Date of Bird (Month, Da		9. Bi	rthplace (State or Foreign ountry) nsylvania
	and and		Usuel Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Loc	cation						10d. Inside City Limits
	e Mary	ctor	Maryland Ha	arford			Fore	st Hi	11			1 ☐ Yes 2XXXNo
3	Mith th	Director	10e. Street and Number			10f. Z	p Code	21050	:	-	zen of What C Jnited	•
	eath	Funeral	1 Colgate Drive	12. Was Decedent Ever in	J.S. 13. V	Vas Dece	dent of Hispanio		ecify Yes or No		14. Race - Am	
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene, is marked other than "naturelt, or items 23a or 28a-f show aumatic event, the Medical Examinational Londilled all	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes   及反No If Yes, Give Year or Dates:			ecify Cuban, Me: 2⊠No Spe		ecify Yes or No Rican, etc.)		Black, Whi	ite, etc. White
Maryland 21215-0036	natur	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Give i	kind of w	ual Occupation ork done during	most of work	ung	16b. Ki	nd of Business	s/Industry
121	within ene. than '	ompi	Elementary/Secondary (0-12) 12 Years	Cottege (1-4or 5+)		emake	use retired)				Own Ho	me
ָם פַ	illed Hygi other	Be C	17. Father's Name (First, Middle, Last)		1101110	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		fother's Nam	e (First, Middle,	Maiden		
/lar	should be ind Mental smarked o umatic eve	To B	Thomas Heinly					My	rtle Wa	ılsh		
Man	l 2 sho h and h and is mu rauma	14	19a. Informant's Name/Relationship (Ty) Louise Kraus /	<sub>Гре, Print)</sub> Daughter		_			al Route Number. Jarre			
	1 and 1 Health tem 27		20a. Method of Disposition		Place of Dispos	sition (Na	ime of		Date		cation - City or	
altimore,	Peges net of I int: If it		1 🖾 Burial 2 □ Cremation 3 □ R  1 □ Donation 5 □ Other (Specify)		cemetery, crem	-		dem. 6	5/30/200	4	Dunda1	k, Maryland
Balti	permii. Peges 1 and 2 should Department of Health and Men Important: If them 27 is marke eny injury or other traumatic once.		21. Signatur of Juneral Service License						Home of			Inc. 21222
75	16		23a. Part1. Enter the disease, or combine shock, or heart failure. List only or	ications that caused the dea	ath. Do not ente	er the mo	de of dying, suc	h as cardiac	indalk, or respiratory a	rrest,	/land	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Lewer	1 Bo	- 1		ment	la			Onset and Death  Syears
	/Medical Examiner		resulting in death)	Due to (or as a conse	uence of):	7	7					Dugas
L	Company of the	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conse	quence of):	5	Dise	ase				10 years
	ate be executed nysicien and he burial-transit	Examiner		C								
760,	te be executed ystcien and e burial-transit	cai Ex	resulting in death) Last	Due to (or as a conse	quence of):							
	ficate physics the			1								
X	th certi ending r use a	an/M	23b. was decedent pregnant	23c. If yes, outcome of pregr		Ectopic	pregnancy			1	23d. Date of de	
P.O. Box	that the death certifica ed by the attending ph detached for use as th	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of 9☐ Unknown		Other (s					Month	Day Year
ر.	is that to	by Ph	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the un	nderlying	cause given in F	Part I.	23e. Did t	obacco u	se contribute t	o the cause of death?
ord	w requires that been signed I should be det	ted t							10	/es 21	No 3□P	robably 4 Unknown
Vital Records,	a 2 2	Completed							24a. Was autop perfo 1 \( \text{Yes} \)		prior to death?	utopsy findings available completion of cause of s 2 No
Vita Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor		h (Check only o			
0	Phys rthis raldir	: To	1 Yes 2 No	28a. Date of Injury	☐ ER/Outpatient 28b. Time of	t 3 🗆 🗅	28c. Injury at	Nursing Ho	28d. Describe			ecify)
ion .	Attending Physician: It death. ector: After this certifica by the funeral director.	atior	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Yeer)	Injury	м	Work? 1 □ Yes	2 🗆 No				
Division of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director. page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	home, farm, stre	et, facto	ry, office			(Street and Number or Rural Route Number, own, State)			
	Hospil 24 hour Funera stely fills	Medical (	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my kr iner: On the basis of examinand manner stated.	nowledge, death	occurre	d at the time, dat n, in my opinion,	te and place, death occur	and due to the red at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the within. To the comple	Mec	29b. Signature and title of certifier	and stated.		25	c. License num	ber		29d. Dat	e signed (Mon	th, Day, Year)
)			Linda a	Walsh M	$\mathcal{L}$		D340	308		6	1/28/2	004
	7		30. Name and address of person who co	- 1 000	om 23a) (Type, I	Print)			.1			MD 2/084.
	-04		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature.	REE	TTSVIL	a ri	) VARRE	-7751	ILLE 1	110 2/084.
	Sta Registr		JUL 0 7 2004	Serve	6	A si	4. 1					

Debra Kay Sipe 04-AKG

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4346	For Unpend Item #23a&27 per me G834 8/3704 tas  Certificate of Death  Reg. No. 1 1 2	1200
Physician /Medical	DEBRA K. SIPE  2. Date of Death Month Day Year July 3, 2004	3. Time of Death 9:10 A
Examiner  Funeral Director	215-56-2469 44 TIS 10/22/1959 MARYL	e (State or Foreign
the Maryland 28a-f show rulling at		. Inside City Limits 1 ☐ Yes 2 ☐ XNo
"1215-0036 within 72 hours after death with the Maryland one. Then "neturel", or Items 23e or 28e-f show the Maryland Exa. illiner; ust be rediffed at ompleted by Funeral Director	0e. Street and Number  8231 BONAIR ROAD  10f. Zip Code  21234  USA  1. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No-	
15-0036 72 hours after d "neturel; or item	Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  Armed Forces?  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  Specify: WHIT	E
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours att f Health and Mental Hygiene. Item 27 is marked other then "neturel", or other treumatic event, It a Mandal Externa	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12TH GRADE  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  TYPE SETTER  16b. Kind of Business/Indus:	try
Maryland 212- nd 2 should be filed within th and Mental Hygiene. 27 Is marked other then retreumatic event, ILE M. To Be Comp	7. Father's Name (First, Middle, Last)  JOHN F. HEATH  18. Mother's Name (First, Middle, Maiden Surname)  DORIS BROWN  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co	orto)
Baltimore, Ma permit. Pages 1 and 2 s Department of Health an Important: If item 27 is s any injuy or other treuu once.	FREDERICK R. SIPE HUSBAND 8231 BONAIR ROAL FALTIMORE, MD 21234  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, cemetery, crematory or other place)	
Baltimore, permit. Pages 1 a Department of Hes Important: If item any injury or othe	*4 Donation 5 Other (Specify)  MORELAND MEM. PARK 7/10/04 HTLLENDALE, MI 21. Signature of Funeral Service Licensee  22. Name and Address of Facility THE JOHNSON FUNERAL HOLE 8521 LOCH RAVEN BLVD. TOWSON, MD 2128	ME, P.A.
icate be executed physician and purial-transit stee burial-transit projection and stee burial-transit projection is the burial-transit projection in the projection is the purial-transit projection in the projection is the projection in the projection in the projection is the projection in the projec	shock, or heart failure. List only one cause on each line.	proximate terval Between nset and Death
S, P.O. Box 68 est that the death certification by the attending probe detached for use as the Physician/Med	FEMALE: 23c. If yes, outcome of pregnancy   23d. Date of delivery   1	y Year
cords, P.  requires that the been signed by should be deta	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause given in Part I.	1/
al Record  In: The law requir ficate has been s  Ir, page 2 should  Completed	Ves 2□No 1 Ves 2□	findings available etion of cause of
Division of Vital Records, P.O. Box 68 the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  The Funner Director: After this certificate has been signed by the attending phy plate Funner Director. After this certificate has been signed by the attending phy physicial by the funeral director, page 2 should be detached for use as the Adelical Certification: To Be Completed by Physician/Medical	examiner?  **Extrem solution   Hospital:   Impatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Home   5   Residence   6   Mother (Specify)   6    27. Manner of Death   28a. Date of Injury   28b. Time of Injury	
Division within 24 hours after death within 24 hours after death or the Funere Director: completely filled in by the Medical Certifical	4 Homicide determined determined 289. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  299. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as states.	d.
To the Hosp within 24 hou To the Funel completely fil	(Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day	
	O.C.M.E. July 4, 2004  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MACH DUM D. K.D. Deu 111 Penn Street, Baltimore, Maryland	21201
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	

Physician   Morth   Day   Comment				1 = For State Registrar	State of Mary		artment of H		lental Hygie	2001	21289			
Examiner  Financi Director  Fi	<b>⇒</b>					ELVAR			Month	Day Zuyear	3. Time of Death			
Usual Relations of Decedent 100. Gardy 100. Total 100. State 100. Cety, Town or Isolation 107. Total 107. Total 108. State 100. Cety 109				FORT WASHING	TON HOLP	ITAL	FORTW	ASHINI		PRINCE G	EURCES			
Top Size   Top Size	Asi Indian			227-07-6530	1 □ M 2 NTE	V			(Month, Dey, Ye Mar. 21,	1914 Vir	place (State or Foreign htty) ginia			
Earnentary/Special Properties   Teach   Teac		Maryland a-f ehow	tor	10a. State 10b. County							10d. Inside City Limits 1   Yes 2   No			
Earnentary/Special Properties   Teach   Teac		h with the		10e. Street and Number					10g.		ntry?			
Earnentary/Special Properties   Teach   Teac	980	urs after deatl	þ	11. Marital Status  1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give	ļ			ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	etc.			
Table   Tabl	21215-0	within ene. then	ompleted	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)	(Give	kind of work done of DO NOT use retired,	luring most of work.	ing 16b		dustry			
20. Mathod of Disposition  1	and	e d al	Be			1								
20. Mathod of Disposition  1	Mary	2 sh and and is m	Ĕ	19a. Informant's Name/Relationship	(Type, Print)			and Number or Run	al Route Number, Ci	ity or Town, State, Zij	,			
Physician (Modical Examiner)  Physic		Pages 1 an nent of Heal int: If item 2 iry or other		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 [	Removal from State	y 6/30,	Date 200 04 Cli	Location - City or To	own, Stete					
Physician (Medical Examiner  Physician (Medical Examiner)  Physici	Balt	permit. Departr Import any inji		21. Signature of Funeral Service Lice	Bessel .			cal Home						
Due to (or as a consequence of):    The past 12 months?   1		/Medical	er	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	g, such as cardiac	or respiratory arrest,	1	Approximate interval Between Onset and Death					
OC C STATE OF STATE O	,092	# % <b>#</b>	Ical Examin	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last		onsequence of):								
25. Was case referred to medical examiner?    1	.O. Box	the death certifica y the attending ph ached for use as the	nysiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetat death 3								
25. Was case referred to medical examiner?    1		equires that sen signed k ould be deta	by		1	ot resulting in the u	nderlying cause give	on in Part I.			he cause of death? pably 4 XUnknown			
26. Place of Death (Check only one)  27. Manner of Death 1 Normalization 28. Place of Death (Check only one)  28. Date of Injury 3 DOA  28. Date of Injury 4 Normalization 28. Place of Death (Check only one)  28. Date of Injury 4 Normalization 28. Date of Injury	I Reco		Comple			4			autopsy	prior to co death?	mpletion of cause of			
The state of the s	f Vita	ysician is certifi director	To Be	examiner?	Hospital: 1 tnpatient	24 ER/Outpatier	t 3 DOA Othe	AP.		a 6 □Other (Specia	(y)			
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		fing After fune		1 ØNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	.?	28d. Describe how i	njury occurred						
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Divi	tal or Att	Certifi		289. Place of injury		eet, factory, office	actory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
30 Name and address of person who completed cause of death (Item 23a) (Type, Print)		ne Hospi n 24 hour ne Funer bletely fill		(Check only 2 Medicel Exa	miner: On the basis of ex-	amination and/or in	n occurred at the time vestigation, in my op	e, date and place, pinion, death occurr	and due to the cause ed at the time, date	ue to the cause(s) and manner as stated, the time, date and place, and due to the cause(s)				
30 Name and address of person who completed cause of death (Item 23a) (Type, Print)			W	29b. Signature and title of certifier	? Omaia	MD			29d.	Date signed (Month,	Dey, Year)			
Or Day God (Mark Day York)		7		SUTAN R.OM	ARA, MD	1711 LIVIA	Print) 10-570N A	ROAD, 6	RT WASHIA	1070N,M	0 20744			
State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature  32. Registrar's Signature	Dhi	Registr	ar			-	Louis	2						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** CHARLES G. SCHULTZ, SR. Month 10:00 AM /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner Rose HOSPITO Square dal imore If Under 24 Hrs. 8. Date of Birth Month, Day, Jan. 27 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 212~20~7069 . 1925 **X**M 2□ F 79 Yrs Mary land Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show other treumatic event, the Mudical Examiner must be notified at Maryland Baltimore Baltimore County 1 Yes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with it and Mental Hygiene.
Is marked other then "neturel", or Items 23a or? 7130 Willowdale Avenue 21206 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑XXYes 2 □ No If Yes, Give Year or Dates! WW 11 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 20XNo Specify. 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Letter Carrier U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles A. Schultz Anna Maria Schlemmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is rr any injury or other treum 9504 Hickory Falls Rd. John M. Schultz (Son) Baltimore, Maryland 21236 20a. Method of Disposition

X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Gardens of Faith Cem. 7~6~2004 Baltimore, Maryland <sup>4</sup> □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 21. Signature of Funeral Services icensee eiss ahn 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Stage a. End disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DΜ Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed 60 Tens Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE . If yes, outcome of pregnancy 1□Live birth 2 □Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: P 1 ☐ Yes 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) in by the funeral 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending death. 1 TYes 2 □ No investigation after death 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide vithin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

ve Baltimore

30. Name and address of person in o completed cause of seator tem 23a) (Type, Print)

OBFRANKIIN

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

Registrar

State

			1 _ State	State of Maryla	•	artment of Heal tificate of Dea		ntal Hygier	211114	21291			
			Registrer  1. Decedent's Name (First, Middle, Last)					. Date of Death	1	3. Time of Death			
	Physici: /Medic		Henrietta Ca	rson Shir	еу			Month 2	Pay Year	- 13 AM			
	Examin		4a. Facility Name (If not institution, give str Brookfield Manor Re			4b. City, Town, or Loca		1	c. County of Deati				
			5. Social Security Number 6. Sex		rs. last birthday)	Middle	_	Date of Birth	Carro	pplace (State or Foreign			
	Funeral Director			M 2 1 F	94 Yrs.		ours Min.	Date of Birth (Month, Day, Yea	909 Penr	nsylvania			
	ס		Usual Residence of Decedent  10a State 10b County	100	City, Town or Lo	antian				10d. Inside City Limits			
	shov	'n	10a. State 10b. County  Maryland Carrol		City, Town of Lo	Union Br	idae			1 ☐ Yes 2X No			
	the N 28a-f	Director	10e. Street and Number			10f. Zip Code	rage	10g. (	Citizen of What Co	untry?			
	death with the Maryland ma 23a or 28a-f show Etriust be codiffed at		770 Quaker Hi	11 Rd.		2179	91		U.S.A	١.			
		Funerai	Tr. Maritar Otatoo	2. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hispani f Yes, specify Cuban, Me	ic Origin? (Speci exican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, White				
ဗ္	hours after tural', or Ite	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 Z*No If Yes, Give Year or Dates:		1 □ Yes 2 ၨXNo Spe	ecify:		Specify: Wh	nite			
ş	2 hour		15. Decedent's Educa	ation	16a. Deced	dent's Usual Occupation kind of work done during	most of working	16b.	Kind of Business/				
215-0036	thin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired) aide	thost of working		bosnite	.1			
2	filed within 72 Hygiene. other then "ne' ent, the Medic		17. Father's Name (First, Middle, Last)	4			Mother's Name (	First, Middle, Maid	hospita en Sumame)	11			
Maryland	ed is b	) Be	George Toward			10.		ia Chome	,, ,				
3	2 should and Men Is marks sumatic	Q.	19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (Street and N		Rural Route Number, City or Town, State, Zip Code)					
	27 15		Warren C. Shirey/		***************************************	Quaker Hill			ridge, MD				
ore	of Hea of Hea of Hea of item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🔀 Re	moval from State	•	natory or other place)	Dat		Location - City or				
Baltimore,	t. Pages ntment of rtant: If it		* 4 □ Donation 5 ☑ Other (Specify E 21. Signature of Funeral Service Ligensee	ntombment Oi					lliston,				
Ba	permit. Pages Department of Important: If it any injury or conce.		a tharine	X/a.Bler	6	R. Name and Address of F E. Broadway		on Bridg					
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the d	leath. Do not ent	er the mode of dying, suc	ch as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death			
	Fnysician	2 7	Immediate Cause (Final disease or condition	Congra	Lue	broant I	ail us			DUAS.			
	/Medical Examiner		resulting in death)	Due to a a con	1			L. 4	1	9			
		-e	Sequentially list conditions, if any, leading to immediate	Due to (or as a con	sequence of):	en 's Carl	Lomay	Mean 1	Lidoseo	Jeans.			
	cuted	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c.										
ő,	cate be executed physicien and the burial-transit		resulting in death) Last	Due to (or as a con-	sequence of):								
8760	icate b physic s the b	dicai	d.										
Box 6	The law requires that the death certificate has been signed by the attending I page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, autcome of pre		75-4			23d. Date of deli	very			
	death ne atte ad for	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnancy Other (specify)		<del></del>	Month	Day Year			
0.0	at the	Phys	9 ☐ Unknown  Part II. Other significant conditions cont		cosulting in the u	adorbina aquas ayas in l	Dart I	23a Did tobacc	n use contribute to	the cause of death?			
	ires tha signed d be dei	b	Part II. Other significant conditions cont	ributing to death but not	resulting in the u	inderlying cause given in	raiti.			babiy 4 Unknown			
Records,	w require been si should l	lete						24a. Was an	24b. Were au	topsy findings available			
Be	The law ate has page 2	Completed						autopsy performed?	death?	ompletion of cause of 2□ No			
Vita	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				Place of Death (		Classic	101111111			
	ding Phyaician: h. After this certific funeral director,	၉	1 ☐ Yes 2 ☐ Mo	ospital: 1 ☐ Inpatient : 28a. Date of Injury	2 ER/Outpatier	the same of the sa		5 Residence		rify)			
on o	ding F h. After funer	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	r) lnjury	f 28c. Injury at Work? M 1 ☐ Yes		d. Describe flow in	july occurred	1			
Division of	or Attending Phyaician: after death. Diractor: After this certifica in by the funeral director, I	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - A building, etc. (Sp	At home, farm, str	eet, factory, office	28	f. Location (Street City or Town, Sta	and Number or Ru	ral Route Number,			
ā	afte Dir	Cert	Tionicas	building, stc. (Sp									
	To the Hospital or Attent within 24 hours after death To the Funeral Diractor: completely filled in by the	edicai				h occurred at the time, da vestigation, in my opinion							
	To the within 2 To the comple	Me	29b. Signature and title of certifier	and manner states		29c. License num	nber	29d. [	Date signed (Month	, Day, Year)			
			Attania	to MM		D0000	000	06	(27/04	1			
	24		30. Name and address of person who cor	mpleted cause of death (	(Item 23a) (Type,	her John T	Zadll	mion Bi	Sige W	1-9522			
	Sta Regist		31. Date filed (Month, Day, Year) <b>JUL 0 7 2004</b>	32. Togistrar's S	ignature	Soc. 1							
					/+	more consideration							

			1- For State of Maryland / Dep	artment of Health and Mertificate of Death	fental Hygier	40 00 1	21202
			Decedent's Name (First, Middle, Last)		2. Date of Death	0.004	3. Time of Death
н	Physici		Fleta Irene Sanquist		June 27	Day 2004	1:40 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
			1380 Platinum Drive	Eldersburg		Carrol	.1
	Funeral		Social Security Number     6. Sex     7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birti	hplace (State or Foreign
	Director		578-03-7019 1 M 2 F 96 Yrs.	Months Days Hours Min.	September		rginia
	pur *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	contine			
	sho	ī	Maryland Carroll Eldersb				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-i	Director	10e. Street and Number	10f. Zip Code	100	Cities and Mallines C	
	should be filed within 72 hours after death with the Maryland of Mental Hygiene marked other than "natural; or items 23a or 28a-1 show imatic event, the Mudical Examination to perceit and marked other than the modified at	Dir	1380 platinum Drive	21784	10g. 1	Citizen of What Co U.S.A.	untry?
	ns 23	Funerai	•	Was Decedent of Hispanic Origin? (Sp.	acify Yes or No-	14. Race · Amer	rican Indian
(0	riter	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No	if Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
ĕ	al', o	by	3 A Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Whi	te
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Maryland 21215-0036	tal H dott	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	en Sumame)	
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a	2 4 5 5		0	ng Address (Street and Number or Rura			
	1 and Health tem 27 other tr		Courtney Sines/ Daughter 1380  20a. Method of Disposition 20b. Place of Disp	Platinum Drive, E			
ğ	Pages nent of H int: If Ite		1. Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Comptent Compten	matory or other place)		Location - City or 1	
Baltimore,	t. Pa ntmer ntant njury			coln Cemetery06/29	/U4 B18	adensburg	, Maryland
Ba	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other once.		21. Signature of Pieral Service Licensee	2. Name and Address of Facility George P. Kalas Fu 5160 Oxon Hill Roa	neral Home	e, P.A.	
	4		23a Party Enter the disease, of complications that caused the death. Do not en	olou Uxon Hill Koa	d, Uxon Hi	III. Mary	
			sneck, or heart tailure. List only one cause on each line.		respiratory arrest,		Approximate Interval Between Onset and Death
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<u>.</u>	res that the de igned by the a be detached i		Part II. Other significant conditions contributing to death but not resulting in the u	adation	One Didashara		
Ś	law requires that the as been signed by th 2 should be detache	by	Fair II. Other argument conductors contributing to death but not resulting in the b	nderlying cause given in Part I.	1 Tes		the cause of death?
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Hecords,	has l	Completed			24a. Was an autopsy performed?	24b. Were aut	opsy findings available ompletion of cause of
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Vital	Physician: this certific al director.	o Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death			
ō	this ald	<b>-</b>	1   Inpatient 2   ER/Outpatier	11 3 DOA 4 Nursing Hor	me 5 Residence 28d. Describe how in		ify)
on	r Attending F er death. rector: After by the funera	tion	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	Work? M 1 ☐ Yes 2 ☐ No	cod. Describe now in	jury occurred	
Division	if or Attendir after death. Director: Al	fica	3 ☐ Suicide 6 ☐ Could not be		28f. Location (Street a	and Number or Rui	ral Route Number
5	0 = 2 =	Certification:	4 Homicide determined building, etc. (Specify)	M	City or Town, Sta		,
	To the Hospital within 24 hours a To the Funeral Completely filled		29a. Certifier (Check only (Ch	occurred at the time, date and place, a	and due to the cause	(s) and manner as	stated.
	he H in 24 he Fi piete	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or yr and manney stated.	vestigation, in my opinion, death occurre	ed at the time, date a	nd place, and due t	to the cause(s)
	To To E	Σ	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month,	Day, Year)
	(		1 4 ship	151999	7	ine 28	th 2004
	5		30. Name and address of person who completed cause or death (Item 29a) (Type,	Print)		4	
			31. Date filed (Month, Day, Year) 32. Begistrar's Signative	Print) 2015 Semen Au	i west	niten 1	Wy 24157
*	Sta Registr	_	JUL 07 2004	Locales		,	
			V 1 LOUT /	1-1			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Month July Yeer **Physician** William Franklin Skipper, Jr. 4:17 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 804 Suburbian Rd. Reisterstown Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 68 219-34-1304 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, Ite Modical Examiner must be rediffied at once. 1 TYes 2 XNo Md. Baltimore Reisterstown Director 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 21136 U.S.A. 804 Suburbian Rd. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 3 Manu. Rep. Fastners Co. 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William F. Skipper Mary Carey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 804 Suburbian Rd., Reisterstown, Md. 21136 Phyllis M. Skipper - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State July 7, 2004 Gamber, Md. Mt. Pleasant Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, Md. 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1149 rea J /Medical ue to (or as a consequence the Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician Box 68760 Be Completed by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a Ö 9 Unknown 9 Unknown ۵ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autoosy performed 1 ☐ Yes 2 ☐ No 2 No 1 Yes Division of Vital luneral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month. Dav. Year) 29b. Signat and title of certifier Ave, D-1, Frederick, MB 2170 erson who completed case of death (Item 23a) (Type, Print) House 31. Date filed 32 Registrar's Signature State Registrar

		For State Registrar	State of M	Maryland / D	-	ent of H ate of L		and M		iene g. No.	04	21294
Physicia /Medic Examin	al .	Decedent's Name (First, Middle, La     RAY SPENCER     As Facility Name (If not institution, give		or)	4b. (	ity, Town, or	Location o	of Death	2. Date of Deat Month JULY	Day 2	Year 2004 ounty of Death	3. Time of Death 2:48 P
Funeral Director		FUTURECARE—SAND 7 5. Social Security Number 6. S	OWN-WINC		day) If Ur	ALTIMO			8. Date of Birth (Month, Day, MAY 30	Year)	9. Birthp	place (State or Foreign ntry) PA
Maryland -f show fied at	lor	Usual Residence of Decedent  10a. State 10b. County  MD		10c. City, Town								0d. Inside City Limits
ath with the 23e or 28s	Funeral Director	10e. Street and Number  2223 AIKEN STREE	CT CT		10f.	Zip Code	18		1	0g. Citize	n of What Cour	ntry?
72 hours after death with the Maryland naturel; or Items 23e or 28e-f show deal Examinet must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	s? ⊈No		scedent of Hi specify Cubar s 2 1 No	spanic Orig n, Mexican, Specify:	gin? (Spe , Puerto I	city Yes or No- Rican, etc.)		Race - Americ Black, White, pecify:	
ges 1 and 2 should be filled within 72 hours after death with the Marylan ges 1 and 2 should be filled within 72 hours after death with the Marylan to file fillem 271 is marked other then "naturel", or flems 23e or 28e-f show or other treumetic event, the Madical Examinat must be notified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		() ()	ecedent's l Give kind of ife. DO NO	Isual Occupa work done d Tuse retired,	ition luring most )	of workin	ng	16b. Kind	of Business/In	
d 2 should be filed th and Mental Hyg 7 is marked othe treumetic event,	To Be C	17. Father's Name (First, Middle, Last, RAY SPENCER, SR	•				MARY	HAV	(First, Middle, M		mame)	
s 1 and 2 sh f Health and item 27 is n other treum		19a. Informant's Name/Relationship ( ROBIN AMOS/DAUG  20a. Method of Disposition	HTER	2.2 20b. Place of D	23 AI	KEN ST	REET	BAI	TIMORE,	MAR		21218
permit. Pages 1 a Department of Hee Important: if item any injury or othe		1 \( \mathbb{R}\) Burial 2 \( \subseteq \text{Cremation} \) 3 \( \subseteq \text{ \subseteq} \) \( \mathbb{C}\) Donation 5 \( \subseteq \text{Other}\) (Specify 21. Signature of Funeral Service Licer \( \mathbb{L}\) \( \ma	()	MT ZIO	N CEM	ETERY	s of Facility	JAM		ORTO	& SON	MARYLAND S F.H.,INC
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tte be nysicia ne bur	Physician/Medicai Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d23c. If yes, outcom	2 Fetal death at time of death		pregnancy (specify)				23d	. Date of delive	ry Day Year
w requires that the been signed by should be detail	۵	Part Other significent conditions of Dementions	ontributing to death	but not resulting in the	ie underlyir	g cause give	n in Part I.			acco use	_	e cause of death?
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or Attending Phy. Ifter death. Director: After this in by the funeral d	ToB	examiner?  1	28a. Date of In (Month, E	tient 2 ER/Outp. jury 28b. Tin lay Year) 28b. Tin lnju njury - At home, farm etc. (Specify)	e of ry M		r: 4 Nurs	sing Hom 2 Io	Check onl one  5 Resider  8d. Describe how  8f. Location (Str.  City or Town,	nce 6 winjury or	curred	,
Hospi 4 hou Funer Funer	edical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exem	ysician: To the besiner: On the basis and manners	st of my knowledge, of of examination and/o stated.	eath occurr r investigat	ed at the time on, in my opi	e, date and inion, death	place, a	nd due to the cal d at the time, da	use(s) and te and pla	d manner as sta	ated. the cause(s)
To the within 2 To the complete	Σ	29b. Signature and title of certifier  Anil Ub	eroi	MD		D20	number 74	8	29	d. Date si	gned (Month, E	Day, Year)
Stat		30. Name and address of person who amy 1 Uberco 31. Date filed (Month, Day, Year)	i MD			-alls	s R	d.	Ba	Ho.	MD	21211
Registra		1111 0 7 20		Sep	1.	274						

		1 - For Stete Registrar	State of	Maryland		artment of tificate o			, ,	giene Reg. No. 1	21205
Physic /Med		Decedent's Name (First, Middle, La		rgie Th	ornto	n			2. Date of Dea Month		3. Time of Death 3:45 Pm. M
Exami		4a. Facility Name (If not institution, giv		ber)		4b. City, Town		of Death	stown	4c. County of I	Death altimore
Funeral Director		215-03-5042	Sex 7 □M X/□F	'. Age (In yrs. Ias 89	t birthday) Yrs.	If Under 1 Yes Months Day		Min.	8. Date of Birth (Month, Day Feb 25,	v, Year)	Birthplace (State or Foreign Country) SC.
e Maryland Ba-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland N	/A	10c. City, 7	Town or Lo		Baltimore	)			10d. Inside City Limits 1 <sup>™</sup> Yes 2 □ No
ath with the 23a or 2	Funeral Director	10e. Street and Number 2210 Linden Ave.				10f, Zip Code	212	17		10g. Citizen of Wha	t Country? .S.A.
urs after dez al', or items	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	No No		Vas Decedent of Yes, specify C			cify Yes or No- Rican, etc.)	14. Race - A Black, N Specify:	American Indian, White, etc. Black
iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If itam 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)			(Give	lent's Usual Occ kind of work dor OO NDT use reti Ho	ne durina ma		ng	16b. Kind of Busin	ess/Industry Home
uld be filed and Aental Hygierkad othar tic evant.	To Be Co	12 17. Father's Name (First, Middle, Last Uk				110	1		10,00	Maiden Sumame) ggie Ross	4.1
nd 2 shoulth and N		19a. Informant's Name/Relationship ( Bernett Cavanaugh	Турө, Print)			•				r, City or Town, Sta ryland 21217	te, Zip Code)
Pages 1 and 2 nent of Health a nut: If itam 27 is iry or other trains		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Special		com	etery, cren	sition (Name of natory or other p tro Cremato	· ·		7/06/04	20c. Location **City  Catonsvil	or Town, State
permit. Pages the permit permit permit of he important: If its any injury or ot once.		21. Signatu of Fundal Service Lice	es		22	Name and Add	Brothers	Funera	Home P.A Itimore, MC	A. ) 21217	
Enysician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. PERI	used the death. ch line. FMERAL r as a consequer	_ VA					rest,	Approximate interval Between Onset and Death
icate be executed physicien and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	r as a consequer	,						
that the death certifica	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live bir	ome of pregnancy th 2 ∐ Fetal de nt at time of deat vn	eath 3	Ectopic pregnar Other (specify)				23d. Date of Month	delivery Day Year
quires that n signed b	þ	Part II. Other significant conditions of	_		-	derlying cause	_	I.			e to the cause of death?  Probably 4 Munknown
sician: The law requir certificate has been si irector, page 2 should b	Completed	ALZHEIME	25	DEME	NTIA				24a. Was a autops perform	sy prior med? deat	a autopsy findings available to completion of cause of h? Yes 2 \sumbox No
ng Phy fter this	ation; To Be	25. Was case referred to medical examiner?  1									Specify)
To the Hospital or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place d building	of Injury - At home g, etc. <i>(Specify)</i>					City or Town	n, State)	r Rural Route Number,
To the Hospital or At within 24 hours after of To the Funaral Diract completely filled in by	edicai	29a. Certifier 1 L Certifying Pr (Check only one) 2 Medicel Exam	nysicien: To the b niner: On the bas and manne	is of examination	edge, death n and/or inv	occurred at the estigation, in my	time, date a opinion, de	nd place, a ath occurre	and due to the cared at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
To the within To the Comp	Me	29b. Signature and title of certifier  W.D  30. Name and address of person who	completed cause	of death (Item 23	За) (Туре, І	Do	0.5910 2	7		9d. Date signed (M ) 7 - 06-  TY +1816	
\ St	ate	KALU UMA mo 31. Date filed (Month, Day, Year)	WESTER	DE ME	DICAL		P B	42-11	MURE	MD 21	215
Regist		JUL 0 7 2004	Gener	a g	de	rocker					

Please Type or Print in Black Indelible Ink. Ens	sure All Copies Are Legible.
State of Maryland / Department of Health	and Mental Hygiene
Certificate of Deat	h Reg. NO. O O I

				rtificate of Death	Reg.	- M - M - M - M	21206					
	Physici	an	1. Decedent's Name (First, Middle, Last)  Lawrence K. Thomson			Day Year	12:03 AM					
	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	JULY	4c. County of Death	14. W AM					
			SINAL HOSPITAL OF BALTIMORE	BALTIMORE CITY		N/A	1					
L	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 215-34-2190 65 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 8/28/193	9. Birth Cou 38 MD	place (State or Foreign ntry)					
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits					
	a-f sh	ctor	MD Baltimore P	arkville			1  Yes 2 <b>∑ X</b> o					
	th with the 23e or 28	al Director	10e. Street and Number 7514 Hillsway Avenue	10f, Zip Code 21234	10g.	Citizen of What Cou						
0000	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23e or 28e-f show or other treumatic event, the Madical Everdiver must be multiply at	by Funeral	1 Never Married 2 Married No ALILY	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes <b>2℃</b> No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Btack, White, Specify:						
ט כ	72 ho	eted	15. Decedent's Education 16a. Decedent's Education (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ing 16b	. Kind of Business/In	dustry					
717	ad within giene. er then '	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 O	Management		Clothing	Business					
מומ	2 should be filed within and Mental Hygiene. is marked other then eumatic event, tre Ma	To Be (	17. Father's Name (First, Middle, Last)  Oliver K. Thomson	18. Mother's Name	ame (First, Middle, Maiden Sumame) na Larson							
Mary	12 should h and Men 7 is marke treumatic	3		ng Address (Street and Number or Rura 25 Arbor Station W								
, ,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre		20a. Method of Disposition 20b. Place of Dispo			Location - City or To						
Dalkillior	t. Pag rtment rtent: li njury o		17 Squrial 2 Cremation 3 Removal from State 14 Donation 5 Other (Specify)  Moreland Me	utimore, Ma	ryland							
Ö	Deparent Important any ir		21. Signature of regeral Service Licensee Victor P. Doda, Jr.	nc. D 21230								
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	21200	Approximate Interval Between Onset and Death							
	Physician Medical		Immediate Cause (Final disease or condition resulting in death)  SEPSIS				3 DAYS					
	Examiner		Due to (or as a consequence of):									
	ed sit	lner	Sequentially list conditions, if any, leading to immediate cause. Emer Uncerving Cause (Disease or injury									
<u>.</u>	execut in and ial-tran	Examiner	that initiated events c.  The control of the contro									
,00100	ntificate be executed ing physician and s as the burial-transit	Medical	d									
O. DOX o	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit	hyslcian/Me		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year					
	that the	۵.	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?					
ה ה	w requires been sign should be	ted by		DISEASE	1 ☐ Yes	2 □ No 3 □ Prob	ably 4 Onknown					
מטכ	Attending Physicien: The law rar death. rector: After this certificate has be by the funeral director, page 2 sh	Completed	ATRIAL FIBRILLATION	24b. Were auto prior to co death? 1 \(\superscript{Yes}\)	psy findings available npletion of cause of							
ומ	icien: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	10 12.00								
5	Physi r this o	1: To										
5	anding l ath. or: After	atlor	2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		,,						
2	0 # 15 E	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,					
	To the Hospitel or Attending Physicien: white 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical (	29a. Certifier (Check only one)  1 ★ Certifying Physician: To the best of my knowledge, death 2 ★ Medical Examiner: On the basis of examination and/or invand manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause ad at the time, date a	(s) and manner as si and place, and due to	ated. the cause(s)					
	To the To the comp	Ň	29b. Signature and title of certifier	29c. License number		Date signed (Month,						
	3	0	30. Name and a dress of per on who comply of cause of death (Item 23a) (Type,	RES-DOO	30	ry 1,90	204					
			MARIA STEPHANIE R. JARDELEZA , MC		AL OF B	ALTIMOR	E					
	Sta	tė	31. Date filed (Month, Day, Year) 32 Registrar's Signature									

State Registrar

DHMH 17 Rev 01

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32 Registrar's Signature

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 0100A Thompson 07 02 /Medical 04 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Fort Washington Fort Washington Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Hours 1 M 2 T Yrs Director 237-54-5149 03 16 29 Seven Springs NO Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28e-f ahow any injury or other traumatic avant, If a Medical Evantrating the retitled at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits DC 1 Yes 2 No Washington Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1301 Upshur Street N.W. #208 20011 Funeral <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify Black þ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postal Stamp Clerk 6th. U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peter Davis Lula Herring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2009 E. Wilson Place Landover, Mp. 20785
per of Disposition (Name of Date 20c. Location - City or Town, State John Thompson, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 7-12-04 Thompson Family Cem JAcksonville, NC 22. Name and Address of Facility MArshall's Funeral Home 21. Signature of Funeral Service Licensee Kall 4217 9th. St. N.W. Washington, D.C. 20011 Mais 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arrhythmia /Medical Due to (or as a consequence of): **Examiner** Hypertensive Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Atherosclerosis and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 4 Pregnant at time of death detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 autopsy certificate 1 Yes 2√ No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 XNo 2 ☐ ER/Outpatient 3 € DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending investigation after death. 1 Yes 2 No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funaral I To the Hospital TSI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medicai (Check only one) and manner stated 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) MD 17310 July 6, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uma Brasad, MD 2100 Pennsylvania Ave. N.W. Washington, D.C. 20037 2. Registrate Signature State Registrar

			For	State of Maryland /	Department of Health and I	Mental Hygie	ne	01000
			Registrar  1. Decedent's Name (First, Middle, La	St)	Certificate of Death	Reg.	Np. UUL	3. Time of Death
	Physici /Medic		Bernice	Tyson		July 3	Day 2004	1 6:40 M
	Examir		4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, or Location of Death	h	4c. County of Deal	th
			5. Social Security Number 6. S	HOSPICE Sex 7. Age (In yrs. last b	oirthday) If Under 1 Year   If Under 24 Hrs.	R Date of Righ	Bal	timore
	Funeral Director			10 M 20XF 75	Yrs. Months Days Hours Min.	8. Date of Birth	928 Nor	thplace (State or Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County	10c City To	wn or Location	7.00	7 - 1 - 1	10d. Inside City Limits
	death with the Maryland mas 23a or 28a-f show	ţō	Mariland NI	A Ra	Itimore			1 Yes 2 □ No
	ith the M or 28a-f	Director	10e. Street and Number	1 1 00	10f. Zip Code	10g.	Citizen of What Co	ountry?
	ath wi		1648 N. App	leton St.	21217		451	A
· ·	fler deal	Funerai	11. Marital Status   1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 7 No	13. Was Decedent of Hispanic Drigin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	erican Indian, le, etc.
93	ours af	by	3 Widowed 4 □ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: B	lack
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryla to f Heatih and Mental Hygiene. It of Heatih and Mental Hygiene. If tiem 27 is marked other then "neturel", or fems 23a or 28a-1 shor or other treumatic event, it a Marylal Examinations to interprete the motified at	Completed	15. Decedent's E (Specify only highest gra		Decedent's Usual Occupation     (Give kind of work done during most of work life. DO NOT use retired)	rking 16b	. Kind of Business/	/Industry
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Maryland	2 should be and Mental is marked o	To	Iom lay	100	Carr	ie B	urns	
Mar	id 2 sh Ith and 27 is n treum		19a. Informant's Name/Relationship (	Type, Print) a ugiter, 19	9b. Mailing Address (Street and Number or Ru	ıral Route Number, Ci	y or Town, State, 2	Zip Code)
ē,	s 1 and 2 of Health item 27 i		20a. Method of Disposition	nom of	of Disposition (Name of tery, crematory or other place)	Date 20c	Location - City or	Town, State
<u>. E</u>	Pa ant:		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specific	THemoval from State	rison Forest 7/13	2/2004 01	Dings	Mill< Md.
Baltimore,	permit. Pages 1 ar Department of Hea Importent: If item eny injury or othe once.		21. Signature of Funeral Service Licer	1see D W	22. Name and Address of Facility	Funera	1 Hame	7,
	40200		23a. Part I Enter the disease, or com	plications that caused the death. Do	o not enter the mode of dying, such as cardiac	e. Baito	. Md. 21	216 Approximate
	Pnysician		shook, or heart failure. List only Immediate Cause (Final	one cause on each tine.	+ CANCER	or roopmatory arroot,		Interval Between Onset and Death
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	Examiner	<u>.</u>	Sequentially list conditions.	b. Due to (or as a consequence	o offi			
<b>%</b> -	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying cause (Disease or injury	Due to (or as a consequence	<b>6</b> Or).		ĺ	
, O	be executed ician and burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence	e of):			
8760	cate phys	dicai		_ d				
Box 6	The law requires that the death certificate has been signed by the attending to bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deli	ivery
a.	ne death the atter hed for u	ician	in the past 12 months?	1☐Live birth 2☐Fetal deat	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
P.O.	that the death ed by the atte detached for	Phys	9 Unknown	9□ Unknown	in the world it is a second of the second of	One Bidankara		
ds,	uires tha signed d be dei	by	Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying cause given in Part I.	1 Yes		othe cause of death?
Records,	w requires s been sign s should be	lete		•		24a. Was an	24b. Were au	itopsy findings available
	The lav	Completed				autopsy performed 1 Tes 2 2	? prior to death?	completion of cause of 2□ No
Vital	Physicien: The I this certificate ha ral director, page	Be	25. Was case referred to medical examiner?	II.		th (Check only one)		11
0	Physic rthis or ral dir	. To	1 Yes 2 No 27. Manner of Death			ome 5 Residence		city) Hospite
ion	Attending I r death. ector: After by the funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Time of Injury at Work?  M 1 Yes 2 No		,,	
Division	or Atterde tirectour by the	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		farm, street, factory, office	28f. Location (Street City or Town, St.	and Number or Ru ate)	ıral Route Number,
םע	pital cours af		29a. Certifier 1 To Certifying Pt	nyeician. To the hest of my knowled	ge, death occurred at the time, date and place	and due to the cause	v(s) and manner as	clated
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai	(Check only 2 Medical Examone)	niner: On the basis of examination a and manner stated.	and/or investigation, in my opinion, death occu	rred at the time, date a	and place, and due	to the cause(s)
	withir To th	ž	29b. Signature and title of certifier	1-0	29c. License number	-	Date signed (Month	
			11 Hother	y Mey, in	0 1792902	10	17 7,0	004
	10		30. Name and address of person who	completed cause of death (Item 23a)	O () JS 205 N. Chales St. Ba	lto md	21204	£
	Sta	_	31. Date filed (Month, Day, Year)	32 Registrar's Signature	4 /2 /			
	Registr	ar	JUL 0 7 200	+ January C	sports			

				artment of Health and Menta rtificate of Death	al Hygiene Reg. No. 0 0 4 2   2 9 9
	Physici		1. Decedent's Name (First, Middle, Last)  CARADY THOMAS	2. Da	te of Death Day Year 3. Time of Death Onth Day Year O951 Am
	/Medio Examir		4a. Facility Name (If not institution, give street and number)  MERLY (TOSP (TAL)	4b. City. Town, or Location of Death 5 AZT711 8 RE	4c. County of Death  N/A
	Funeral Director		5. Social Security Number  6. Sex  2.12 - 44 - 4067  Usual Residence of Decedent		te of Birth onth, Day, Year)  2. H 02, 1945  WORTH CAROLINA
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itama 23a or 28a-f show with injury or other traumatic event, I're Mudical Examiner must be notified at once.	ctor	10a. State 10b. County 10c. City, Town or Lo	BALTIHORE	10d. Inside City Limits 110 Yes 2 □ No
	h with the	Funeral Director	4815 LAUREL AVENUE	10f. Zip Code 21215	10g. Citizen of What Country?  USA.
.=	Itama 2	-uner		Was Decedent of Hispanic Origin? (Specify Yolf Yes, specify Cuban, Mexican, Puerto Rican,	
5-0036	nours af ural', or	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ŽNo Specify:	Specify: BLACK
215-	within 72 tene. Than "nate	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
2	filed with Hygiene Ithar tha			UO TECHUICIAN  18. Mother's Name (First.	BLACKMANS PIANO CO, Middle, Maiden Surname)
Maryland	should be find Mental Hammarked of	To Be	CLAUDE P THOM	1.20.0	
Mar	nd 2 shouth and 27 lamuratranma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailii  MARGARET THOMAS (WIFE) 48	ng Address (Street and Number or Rural Route	100
ore,	ges 1 and 3 t of Health If itam 27 or other tra		20a, Method of Disposition 20b, Place of Dispo	osition (Name of pater)  Date	BALTIHORE MD. 21215  20c. Location - City or Town, State
Baltimore,	permit. Pag Department Important: I any injury o once.		* 4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee	VEMETERY DI-09-0 Name and Address Facility DRO	OY LANSDOWNE, MD.
ä	permi Depar Impo any ir		Lutured N. Williams	AVE. BALTO. MD. 21217	
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. SCDS S S7~C		ratory arfest, Approximate Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Sepsil 5 57 20 Due to (or as a consequence of):		at n.
	D ##	ner	Sequentially list conditions, Tary, leading to inmediate cause. Enter Underlying Cause (Disease or injury		
	ate be executed hysician and the burial-transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):		
8760,	cate be executed physician and the burial-transit	dicai	d		
Box 6	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	Physician/Medicai		Ectopic pregnancy Other (specify)	23d. Date of delivery  Month Day Year
ds, P.O.	uires that i signed by id be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderfying cause given in Part I. 23	le. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Thicknown
Records,	law requir as been si 2 should	Completed	Diebetes Mellils	24	a. Was an autopsy findings available prior to completion of cause of
Vital R	10	e Con	Hypertonsien  25. Was case referred to medical		performed? death?  Yes 2 No 1 Yes 2 No
of Vit	Physician: this certific	To B	examiner?  1 □ Yes 2 □ FR/Outpatier		Residence 6 Other (Specify)
ion	Attending P ir death. actor: After t by the funera	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	f 28c. Injury at 28d. De Work?  M 1 ☐ Yes 2 ☐ No	scribe how injury occurred
Division	Dir.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, Iarm, str building, etc. (Specify)		cation (Street and Number or Rural Route Number, y or Town, State)
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in h	edical C	29a. Certifier (Check only one)  Check only one)  Check only one)  Check only one)  Check only one)  Check only one)	n occurred at the time, date and place, and due vestigation, in my opinion, death occurred at th	e to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)
	2000			29c. License number	29d. Date signed (Month, Day, Year)
		W	29b. Signature and with of certifier	242637	July 1, 2004
)	To the within Within Comple	Me	30. Name and address of person who completed cause of death (Item 23a) (Type,	142637	July 1, 2004

State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #9,11,12,15,16b,17,18&199111102180011110 G833 7/07/04 NJH 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death **Physician** Month Year Alfred Trotman /Medical Tune 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BALLAM If Under 24 Hrs. -ORIEN RUGRSIDE AL FORA 5. Social Security Number If Under 1 \ 7. Age (In vrs. lest birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1**∑** M 2□ F Months Days Hours Min 243-18-5528 Director 83 VIRGINIA 1921 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City. Town or Location worde 10d. Inside City Limits Harford Be1camp Director 1 ☐ Yes 2X No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1123 Belcamp Garth 21017 Funeral USA unk 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ 3X Widowed 4 □ Divorced Specify 20vrs white Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) Health and Mental Hygiene. em 27 la marked other than College (1-4or 5+) 8 U.S.AIR FORCE 17. Father's Neme (First, Middle, Last) 1111/2 18. Mother's Name (First, Middle, Maiden Surname) CLARENCE TROTMAN DOROTHY WHITEHURST 9a. Informant's Name/Reletionship *(Type, Print)* THERESA\_EOOKER/stepdaughter Department of Health a Important: If Item 27 Is any Injury or other tra once. altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☒Other (Specify) in state Signature of Puneral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street rector 100 Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uee contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □ Unknown ģ Completed 24b. Were autopsy findings available prior to completion of cause of death? Fibrillation / Alateiners denertic 24a. Was an eutopsy performed? page 2 si 2LMNo this certificate I Ves 1 ☐ Yes 2 ☐ No Hoepital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ KONO Medical Certification: 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Naturel 5 Pending investigation within 24 hours aftar death.

To the Funeral Director: Af
complataly filled in by the fu 2 Accident 1 □ Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) Clivo 615 own 31. Date filed (Month, Day, Year) 32. Registrer's Signature State JUL 07 2004

DHMH 16 Rev 6/95

Registrar

			1 - For Stata Ragistrar	State of M	Marylan		artmen			and M	lental Hy	giene	100	2130	
П	Physic	ian	1. Decedent's Name (First, Middle, La Leroy William T	•							2. Date of De Month	Day	_	3. Time of Deat	
>	/Medi Examii		4a. Facility Name (If not institution, gir Union Memorial	ve street and numbe	or)				Location o		July	4c.	2004 County of De		-\$ IVI
	Funeral Director			Sex 1 ☑ M 2 ☐ F	Age (In yrs. 77	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir OCT 0,	rth 1 <sup>1</sup> 9 <sup>2</sup> 2 <sup>1</sup> 0	9. B Sot	irthplace (State or Fore	∍ign 1a
	iryland show	_	10a. State 10b. County		10c. Cit	y, Town or Lo								10d. Inside City Lim	nits
	the Ma 28e-f g	Director	MD 10e. Street and Number			Ba1	timor							1 X Yes 2 □	No
	h with 23a or		2831 Pelham Ave	nue			10f. Zip		21213			10g. Citi	zen of What ( USA	Country?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28e-1 show appring to other treumatic event, I'm Medical Evariting must be rediffed at QDGs.	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force: 1 X Yes 2 If Yes, Give Year or Dates	s? ∃No	1	Was Deced f Yes, spec		spanic Origin, Mexican,	in? (Spe Puerto I	cify Yes or No Rican, etc.)	)-	14. Race - Am Black, Wh Specify: W		
Maryland 21215-0036	within 72 ho lene. 'then "natur the Medical	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0·12)	ducation		16a. Deced (Give life.		_	tion uring most perso		ng	16b. Kii	nd of Busines	s/Industry UI	nk
yland 2	should be filed and Mental Hygid s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last Fred Joesep	,	n				18. Mother	's Name	(First, Middle, Emily				
Mar	d 2 sho th and t7 Is m treum		19a. Informant's Name/Relationship ( Joyce Thompson/s	* * * * * * * * * * * * * * * * * * * *							Route Number			Zip Code)	
Baltimore,	Pages 1 and ment of Health ant: If item 27 ury or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 🛣 Donation 5 ☐ Other (Special	20a. Method of Disposition  1									21213 cation - City o	r Town, State	
Balt	permit. Departr Imports eny inju		State Anatomy Bo. Baltimore, MD 2										ltimore	Street	
	Anysician /Medical Examiner		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Pulmonan Edema  Due to (or as a condequence of):								respiratory ar	rest,		Approximate Interval Between Onset and Death	
8760,	ficate be executed physician and is the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a											
P.O. Box 68	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 - Fetal	death 3 🗌	Ectopic pred Other (spec					23	3d. Date of de Month	livery Day Year	
rds, F	w requires tha been signed should be dei	by	Part II. Other significant conditions of	ontributing to death	but not resu	lting in the un	derlying cau	ise giver	in Part I.			bacco us		the cause of death?	٧n
		e Completed	© 25. Was case referred to medical								prior to death?	utopsy findings availab completion of cause of	le		
0	ng Phys fter this neral di	atlon; To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1X Inpati 28a. Date of Inj (Month, Da	ury	ER/Outpatient 28b. Time of Injury		Other . Injury a Work?	4 🗌 Nurs	ing Hom	e 5 Resid	ence 6		cify)	
	tal or Attending Is after death. el Director: After ed in by the fune	Certification;	3 Suicide 6 Could not be determined	289. Place of in	jury - At hon tc. (Specify)	ne, farm, stre	et, factory,				If. Location (S City or Town	treet and n, State)	Number or Re	ural Route Number,	
	I o the Hospital of within 24 hours at To the Funerel D completely filled in	Medical	one)	ysician: To the best niner: On the basis of and manner s	or examination	rledge, death on and/or invi	estigation, ir	n my opir	nion, death	place, an occurred	at the time, d	ate and p	lace, and due	to the cause(s)	
,	To COI	- 1	29b. Signature and title of certifier .	· Ms				icense r		16 -			signed (Monta	h, Day, Year)	
			four House 30. Name and address of person who a 201 E. Univer	completed cause of	death (Item :	23a) (Type, P	rint) 30	cel	70 /	Hin	es, n	ND	ya,	2004	$\dashv$
	Cha		201 E. Univer	Sity Vki	rar's Signati	Balt	MORE.	, N	1ARV	LAN	0 21	215			
· 1	Registra	UII A W ARRA													

State of Maryland / Department of Health and Mental Hygiene 1- State AMEND ITEM #1 PER PHY G833 7/07 entire at the of Death 2. Date of Death MARIE CLARKE VALIGHAN 1. Decedent's Name (First, Middle, Last) Physician Month June 2004 VAUGHAN MARTE CLARK 12:40 AMM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. (Month, Day, Year)

Nov. 9, 19 Frederick Frederick Memorial Hospital
Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F 84 175-12-3737 Pennsylvania Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23e or 28e-f show other traumetic event, the Medical Examiner must be inclified at 1 XYes 2 No Directo Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33 E. George St. 21793 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Maritaf Status 1 Never Married 2 Married 1 ☐ Yes X No Specify: Specify: þ White 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "na any Injury or other traumatic event, the Madic 2008. Elementary/Secondary (0-12) College (1-4or 5+) inventory supply specialist federal government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William O. Clarke Catherine Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lenore T. Lawrence/ daughter 207 Oak Manor Way Walkersville, MD 21793 20b. Pface of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removaf from State St. Peter's Cemetery 6/28/2004 Libertytown, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Fufferal Service Licensee 11802 Liberty Rd. Libertytown, MD 21762 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) AZRICO ABDOMING **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner PREFEREL QUPMIC Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 nrame Reve 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? H(O certificate has autopsy performed CORD 2 \( \text{No} \) 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Mospitel or Attending Pl 24 hours after death. Funerel Director: After to Injury at Work? 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Mospitel c within 24 hours af To the Funerel D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Francisco Vacanos HO06/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A Daniels, Do PATRICK ST. Francesco 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2004 Registrar

LAVONNIE BELL WILLIAMS Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 43201- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1- Reg. No. dap Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Month Day **Physician** JULY 8:05a 2004 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BROOKLYN PARK ANNE ARUNDEL 146 WEST MEADOWS ROAD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 AR 5. Social Security Number 6. Sex 7. Age (la yre last birthday) 8. Date of Birth **Funeral** Days 1 □ M 2 🗷 F Director sual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23s or 28a-f show to Medical Exeminational benefitted at 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, If a Madic ones. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) lears 17. Father's Name (First, Middle, Last) 19b Mailing Address (Street and Numi 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death Part1. Enter the disease, shock, or heart failure. Lis mplications that cause ly one cause on each Immediate Cause (Final **Physician** disease or condition resulting in death) Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for es 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of deaty?

1 ▼Yes 2 □ No 24a. Was an autopsy performed? 2 No 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA XXResidence 6 Other (Specify) Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? al or Attending F s after death. 1 Natural 2 Accident 5 Pending investigation Injury 1 TYes 2 No Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JULY 03, 2004 OCME (M) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) U 111 Penn Street, Baltimore, Maryland 21201 MANG SOUTS KOREL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 7 2004

			1 - For State Registrar		State of	f Mary	land / Dep <i>Ce</i>	artment				lental Hy	giene	001	21304
	Physici	ian	1. Decedent's Name (First, Mic									2. Date of Do Month JULY	eath 2,0ay	y 200 <sup>Year</sup>	3. Time of Death
>	/Medic Examir	cal	JOHN ROBERT  4a. Facility Name (If not institu  1533 ORLANDO	ion, give s		nber)		4b. City,		Location		JULI	4c.	. County of Deat BALTIMOF	
	Funeral Director		5. Social Security Number 217–24–0348	6. Sex	M 2□F	7. Age (In 73	yrs. last birthday Yrs.			If Under Hours	Min.	8. Date of Bi Month D 8/6/1	rth av <i>Year)</i> 930	9. Birt Co MA	hplace (State or Foreign untry) ARYLAND
	yland		Usual Residence of Decedent 10a. State 10b. Cour	nty		100	c. City, Town or L	ocation							10d. Inside City Limits
	the Mar 28a-f s	Funeral Director	MD B	ALTIN	ORE			10f. Zip		KVILI	ĿΕ		10g. Cit	tizen of What Co	1 ☐ Yes 2 No untry?
	ath with s 23a or ust be	rai Di	1533 ORLANDO							21234				USA	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Example in untibe notified at	þ	11. Marital Status  1 □ Never Married 2 → N 3 □ Widowed 4 □ Divord	arried	I2. Was Dece Armed Fo 1 Tyyes If Yes, Giv Year or Do	rces? 2 □ No 'e #/	DREA	Was Deced If Yes, spec		spanic Or n, Mexica Specify		ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, White Specify: WF	
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d 21	filed within Hygiene. other then "	Be Con	17. Father's Name (First, Midd		YEARS		DEPT.	MANAC	GER	18. Moth	er's Name	e (First, Middle		XON CORE	· .
Maryland	should be and Mental markad o	ToB	JOHN J. WARE		0.14		401.44.7		(2)			AGNES			
	1 and 2 sho Health and em 27 is ma sther trauma		19a. Informant's Name/Relation		FE		1	ORLAI				RKVILLE		21234	(ip Code)
altimore,	0 0		20a. Method of Disposition 1		emoval from	State	Ob. Place of Disp cemetery, cre DULANEY	matory or ot	ther place		7/7/0	Date 04		ocation - City or KEYSVILI	
Balt	permit. Pag Department Important: I any injury o		21. Signature Funeral Servi	e License	s. Her	ep		2. Name and			TUE	JOHNS D. TOW	ON FI	UNERAL I MD 2128	HOME P.A.
	Physician		23a. Part1. Enter the disease, shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)	or compli	cations that cause on	aused the ach line.	estive	ter the mode	e of dying	such as	cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death
8760,	Medical Examiner whisician and the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			or as a con	nsequence of):	Year	rte	Dis	easi	2			Zi years
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2		irth 2 🗌 ant at time	Fetal death 3	⊒Ectopic pre ⊒ Other (spe						23d. Date of deli Month	very Day Year
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of Vital Records,		Completed										24a. Was auto perfe 1 \( \text{Yes}		prior to death?	topsy findings available ompletion of cause of
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Division of		Certification; T	2 (37,0010011)	ding stigation	28a. Date of (Mont	of Injury h, Day Yea	28b. Time of Injury	of 28	Bc. Injury Work 1  Y		No	28d. Cescribe	how injur	y occurred	,
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	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier 1 Certifier (Check only one)	ying Phys el Examir	icien: To the ier: On the ba and mann	asis of exam	r knowledge, dea mination and/or in	th occurred a evestigation,	in my op	e, date ar inion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
	To t	Σ	29b. Signature and title of cent	fier		-tw	)	29c.	License	number	56	7	29d. Dat	te signed (Month	Day, Year)
	Ox,	ato	30. Name and address of pers  Francis 4  31. Date filed (Month, Day, Ye	lie	ma	of death	(Item 23a) (Type	Print)	55/	Er	KR	d. A	411	1/Loth	erville, 1,21093
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			Registrar  1. Decedent's Nam	e (First, Middle	, Last)				ate or	Death		2. Date of D		-	14.	3. Time of D	eath
	Physici /Medic		ERIC DV	JAVNE I	אדד.ד.דד							Month JULY	0		Year 2004	3:15a	М
	Examin	1	4a. Facility Name (	If not institution,	give street and n	u <i>mber)</i>			ity, Town, o						y of Deatl		
	Funeral	§ .	5. Social Security N		6. Sex	7. Age	(In yrs. last birthd	ay) if U	nder 1 Year	If Under	r 24 Hrs.	8. Date of E (Month, L	Birth			nplace (State or a	Foreign
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	yland		Usual Residence of 10a. State	10b. County			10c. City, Town or	r Location							10d. Inside City	Limits	
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	with the or 2		10e. Street and Nu 623 RAD		VENUE				Zip Code 1212				-		What Co	-	
	Jeath w	Funeral	11. Marital Status		12. Was De	cedent E	ver in U.S. 1			lispanic Or	rigin? (Spe	ecify Yes or N Rican, etc.)				ncan Indian,	
036	ours after death with the Maryla ral', or Itams 23s or 28e-f shov Examinat must be notified at	þ	Never Mars	ried 2 Marri 4 Divorced	Armed Fed 1 ☐ Yes If Yes, G Year or	orces? 2 No ive Dates:	0		specify Cuba s 2∰ No	an, Mexica Specify:		Rican, etc.)			ick, White $_{\mathit{fy}}$ : $\mathrm{BL}_{\mathit{I}}$		
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0											(First, Midd	le, Maide	n Sumai	me)			
ılan	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura									WILL	ΙE						
Mary											-			ip Code) • 21212	2		
	DOLORES WILLIE (GRANDMOTHER) 623 RADNOR AVEN									Date	,			own, State	<u></u>		
Baltimore,	MT. ZION CEMETERY 7/6/0									04	LAN	SDO	WNE	,MARYLA	AND		
Balt	permit. Departr Importa any inji		21. Signature of 5	uneral Service I	EWIS	T.	GWYNN	22. Nam LEW	e and Addre	ss of Facili GWY	ity NN I	FUNERA	AL H	OME	21	1215-63	393
The second second	rnysician /Medical Examiner	her	23a. Part1. Enter shock, or het Immediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event	art failure. List (Final on	b	o (or as a	the death. Do not	e (=	mode of dyir	ng, such as	cardiac o	S AVEI or respiratory	arrest,	BA	.LTO.	Ap roximate Interval Betwee Onset and De	eath
68760,	cate be executed physician and the burial-transit	dical Examiner	Cause (Disease or that initiated event	r injury s	c. Dus to	u (ur as a	сопзадавное об).										
P.O. Box 6	Attanding Physician: The law requires that the death certificate beingeath. roteath. sctor: After this certificate has been signed by the attending physicia by the funeral director, page 2 should be detached for use as the buri	Physiclan/Medica	IF FEMALE: 23b. Was deceder in the past 12 1  Yes 2 9  Unknown	2 months?		birth 2 gnant at t		3 □Ectop 5 □ Othe	ic pregnancy (specify)	/					ate of deli	very Day Ye	oar .
	uires that signed b Id be deta	by	Part II. Other signi	ificant conditio	ns contributing to	death bu	t not resulting in th	e underlyi	ng cause giv	en in Part I	l.			use con		the cause of dea	
Vital Records,	e law requir has been si je 2 should l	Completed										24a. Wa	as an opsy	24b.	Were aut	topsy findings av	allable
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70	ding Phys n. After this funeral di	n; To	27. Manner of Dea	ith	28a. Date	Inpatien e of Injury onthy Day	/ 28b. Tim	e of	28c. Injur Wor	4 🗆 140		me 5 Re 28d. Describ				(	
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Division	l or Attandi after death. Diractor: A	Certification:	3 ☐ Suicide 4 ☐ Somicide	6 🗌 Could r determi	incd 400. Flat	de of Injuiding, etc.	ry - At home, farm, . (Specify)	street, fa	ctory, office			28f. Location City or T	(Street a	nd Num.	ber or Ru	ral Route Numbe	A.
_	To the Hospital or Attend within 24 hours after death To the Funaral Director; completely filled in by the	calC	29a. Certifier (Check only	1 Certifyin	g Physicien: To th Exeminer: On the	ne best of	f my knowledge, d	eath occu	red at the tir	ne, date ar	nd place,	and due to the	e cause(s	s) and m	anner as	stated.	777
	thin 24	Medical	29b. Sig. ture to	title o certifier	and ma	nner stat	ed.		29c. Licens							, Day, Year)	
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10-	17		JUA	euns	who completed cal	use of de	ach (Item 23a) (Ty		Penn	Stree	et, B	altimo	re, l	Mary	land	21201	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 5:00 AM Anna Wilson July 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3119 River Drive Road Edgemere Baltimore Co. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ KF Vrs Pennsylvania Director 140-20-2662 June 30,1909 Usual Residence of Decedent r 28e-1 show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Yes 2 No Director Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23e or The Medical Examiner must be 3119 River Drive Road 21219 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 'natural', or Items 11. Marital Status withIn 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify δ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Importent: if I tem 27 is marked other the any injury or other treumatic event. It a gare. Own Home 12 Years Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lewis Shiplee Anna Ballingal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth S. Foulke/Sister 3119 River Drive Road Edgemere, Maryland 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2XI Cremation 3 □ Removal from State iltop Service Corp. 7/6/2004 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) weral S 21. Signiture of 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Alghemera dementa **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Annemia Sequentially list conditions, if any, leading to infraediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or, Examine iding physician and ise as the burial-transit certificate be executed CERD that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Carred openties with bindrew Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Tunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 **X**No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending Pl
 A hours after death.
 Funerel Director: After the Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of Within 24 hours at To the Funerel D 29a. Certifier i 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) tile of certifier 29b. Signature and 10055171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTMORE MO SERASTIAN JUITNI 3023 EASTERNI AVENUE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Carolyn Baggette White June 20. 10:00 A<sup>M</sup> 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Hours Min 1 ☐ M 2 □ XF Director 1921 South Carolina 249-26-0803 4, Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20906 3479 S. Leisure World Blvd. U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 Never Married 2 Married ☐Yes 2XNo 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White If Yes, Give Year or Dates: þ 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Public Education 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Hannah Elizabeth Ridgeway Robert Clarence Baggette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traun once. Lois B. Turner - Sister 3479 S. Leisure World Blvd., Silver Spring, MD 2090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Manning Cemetery 6/24/04 Manning, SC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Stephens Funeral Home & Crematory
304 N. Church St., Manning, SC 29102 21. Sign ture of Funeral Service Licens ennis 1) tomen Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lection with Jepsis are Pnysician /Medical : Etcology Uncertain **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 use as the IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 2 No Month Dav 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2 No or Attending Physicien: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 2 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined illed in by 4 Homicide Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 20, 2004 ms 0 20906 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LREND-FERRIS UP 335 North Lesser Culture Societa (1611) 230 (1800) CUNANSOCILENCES Se (VIL Seving Money Mayer

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 07 2004

32. Registrar's Signature

			1 - For State Registrar	State of Marylar	nd / Depa		Health and	Mental Hy	•	21308
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last Color Co	Street and number)	FLLA	4b. City, Towr	, SL n, or Location of Dea PAUSTO	2. Date of Dea Month JULY	Day Year 6 200 4  4c. County of Death	3. Time of Death Y S M
	Funeral Director			x 7. Age (In yrs MAM 2□F 69	. last birthday) Yrs.	If Under 1 Ye Months Day		8. Date of Birt Month, Day Dec	o, 1934 Mary	place (State or Foreign
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Md. Baltimo:		ity, Town or Lo Owings				1	0d. Inside City Limits
	h with the	Funeral Director	10e. Street and Number	ate Rd.		10f. Zip Code	L117		10g. Citizen of What Cour	•
036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artenient of Health and Mental Hygiene. ortant: If Item 27 Is marked other then "naturel", or Items 23a or 28a-f show injury or other traumatic avent, Tre Medical Exertification in clinical at the second of the continuation of the second of th	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces?  1  Yes 2  No If Yes, Give Year or Dates:	1	Vas Decedent of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer No <i>Specify:</i>	Specify Yes or No- to Rican, etc.)	14. Race - Amend Black, White, Specify: Whi	etc.
Maryland 21215-0036	within 72 horiene. then "nature Tre Medicul I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	lent's Usual Oct kind of work do DO NOT use ret cefighte	ne during most of wo ired)	rking	16b. Kind of Business/In Balto. Cit;	
yland 2	ould be filed Mental Hygi harkad other hatic avent, I	To Be Co	17. Father's Name (First, Middle, Last)  George Antho				18. Mother's Na	th Bagen	_	
$\geq$			19a. Informant's Name/Relationship (7) Carol A. Walla	ce - Wife	109 V	Vilgate	Rd., Owir	ngs Mills	r, City or Town, State, Zip , Md. 21117	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 eny injury or other tr once.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from State	cemetery, cren	sition (Name of natory or other p v Mem. ]	olace)	9, 2004	20c. Location - City or To Sykesville,	
Balt	permit. Departr Importa eny Injo		21. Signature of Fuyeral Pervice Licens	P.A. Owings Mills	21117 s. Md.					
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	rest,	Approximate Interval Between Onset and Death					
1760,	icate be executed physician and s the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conse						
.O. Box 68	The law requires that the death certificats tie has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3□	Ectopic pregna Other (specify)			23d. Date of delive Month	ery Day Year
ds, P	uires that signed b	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the ur	nderlying cause	given in Part I.	23e. Did to	bacco use contribute to the	4
25. Was case referred to medical examiner?  1 Yes 2 No  25. Was case referred to medical examiner?  1 Yes 2 No  26. Place of Death (Check only one)  27. Manner of D ath  28a. late of Injury (Month, Day Year)  28b. Time of Injury Work?  28c. Injury at Work?  28c. Injury at Work?								sy prior to condeath? 2 1 Yes	psy findings available impletion of cause of	
								dome 5 ☐ Resid	ence 6 Other (Specify	y)
Division	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, str ify)	eet, factory, offic	ce	28f. Location (S City or Tow	Street and Number or Rura n, State)	l Route Number,
	ne Hospita n 24 hours ne Funerel	Medical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	rsician: To the best of my kn iner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the restigation, in m	e time, date and plac ly opinion, death occ	e, and due to the ourred at the time, o	cause(s) and manner as state and place, and due to	tated. the cause(s)
)	To the within 7 to the comple	M	29b. Signature and title of certifier	Neur le	N	C		33		200 J
	5		30. Name and address of person who c	ompleted cause of death (Ite	em 23a) (Type	ALTO.	MP	21133	>	
	Sta Regista		31. Date filed March, Day, Year 004	321Regaistean's Sign	nature 4	fork.	i			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** JEROLD DEAN WINGEART /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST CENTER TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 80 382-14-4436 Yrs. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-1 show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE PARKTON 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? ō 2307 MT. CARMEL RD 21120 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ CIVIL ENGINEER ENGINEERING other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fi and Mental F is marked ot JOHN M. WINGEART MINNIE KOCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 CAROLYN WINGEART(WIFE) 2307 MT. CARMEL RD PARKTON, MD. 21120. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State CARMEL CEMETERY 07/09/04 PARKTON, MD. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO 21. Signature of Funeyal Service Licensee 16924 YORK RD MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death liver Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner no-occustik disease LOTER Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö the 9 Unknown څ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? cate has to certificate 2 T No 1 Yes 2 No 1 TYes Division of Vital director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 0 1 ☐ Yes 2 🛣 No 4 Nursing Home 5 Residence 6 Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending Injury 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death in 24 hour.
the Funeral Dire. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. CHAYLE 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 07 2004 Registrar

					delible ink. Ensure A	•		
			For State		artment of Health and I		2001. 21210	
			Registrar	Cei	rtificate of Death	Reg. N		
- 6	Physici	an	Decedent's Name (First, Middle, Last)  AND THE TO THE TAX TO				ay Year 3. Time of Death	
4	/Media		ANNIE K. WHISTINE		45 Cit. Town and acceptant of Document	JUNE 27,	200/ <sub>1</sub> 6:15 A <sup>m</sup>	
	Examir	er	4a. Fecility Name (If not institution, give street and r Prince George's Hospital Cer		4b. City, Town, or Location of Death		Prince George's	
ien.	<u> </u>		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Cheverly If Under 1 Year If Under 24 Hrs.			
	Funeral Director		227-32-2045 1□ M 2□xF	90 yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea, August 12,	r) 9. Birthplace (State or Foreign Country) 1913 North Carolina	
	*		Usual Residence of Decedent			710000 123	1919 TOTAL CALOTHE	
	rylan how		10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits	
	Ba-1 e	cto	Maryland Prince George's		Chapel Oaks		tXYes 2 ☐ No	
	ith th 20 20	Dire	10e. Street and Number 1402 Early Oak Lane		10f. Zip Code 2074	.3 10g. C	itizen of What Country? U.S.A.	
	filed within 72 hours after death with the Maryland Hygiene, uther then "natural", or tlems 23a or 28a-1 ehow uther, the Medical Exeminer must be notified at	Completed by Funeral Director						
	er de Items	une	Armed	Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.	
36	rs aft	oy F	1 Never Married 2 Married 1 Yes, 1 If Yes, 2 Year or Year or	s 2 XNo Give Dates:	1 ☐ Yes 2 No Specify:		Specify: Black	
Maryland 21215-0036	thou stura	ed	15. Decedent's Education	16a. Dece	dent's Usual Occupation	16b.	Kind of Business/Industry	
5	n n	piet	(Specify only highest grade complete:  Elementary/Secondary (0-12) College	(Give (1-4or 5+)	kind of work done during most of wor DO NOT use retired)	rking		
212	d with giene grene	E O	3rd grade	Off	ice Cleaner	Ag	riculture Department	
ğ	e file al Hy othe vent,	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, Maide	n Sumame)	
<u>ā</u>	should be nd Mental marked o	To	Samuel Knox			Annie Lee Ber	rry	
a	2 sho and I		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Ru			
	and ealth m 27		Linda L. Warren (Daughter)		Iverson Street Temple			
altimore,	Pages 1 nent of H int: If Iter iry or oth		20a. Method of Disposition  1 ☑Burial 2 ☐ Cremation 3 ☐ Removal fro	20b. Place of Dispo cemetery, crei	matory of other place) morial Cenetery July	3. 2004 I at	Location - City or Town, State	
Ē	Fant:		* 4 □Donation 5 □Other (Specify)					
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a 4 show any injury or other fraumatic event, the Medical Examiner must be notified as once.		21. Sgnature of Funeral Service Licensee	//		OLLINS FUNERAL		
	40200		23a. Part. Enter the disease, or complications tha		339 HNT PLAE, N.E.		Approximate	
8			shock, or heart failure. List only one cause or	n each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Interval Between Onset and Death	
	Physician (Madies)		Immediate Cause (Final disease or condition resulting in death)	Long a	nto disea	ne		
	/Medical Examiner		, ue	o (or as a cons y ueric of):	0011.	17		
		<u></u>	Sequentially list conditions, b.	u (u as a consequence of):	new gar	ene-		
	ted nsit	in in	cause. Enter Underlying Cause (Disease or injury					
	al-tra	Examiner	that initiated events c.	o (or as a consequence of):				
760,	The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	al						
89	ficate g phy as the	edic	- U					
Вох	anding use	N/U		outcome of pregnancy	Tetaria arasana.		23d. Date of delivery	
m.	that the death certificat ed by the attending phy detached for use as th	Physician/Medi	in the past 12 months?	gnant at time of death 5[	Ectopic pregnancy   Other (s <i>pecify)</i>		Month Day Year	
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S.	w requires that s been signed t should be det	by P	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?	
Ë	aquire en siç	ed				1 🗆 Yes	2 □ No 3 □ Probably 4 ☑ Unknown	
သို	law re as be 2 sho	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	
æ	The lav	E O				performed?	death?	
ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?		26. Place of Dea	ath (Check only one)		
Division of Vital Records,	Attending Physician: of death. ector: After this certifici by the funeral director, i	10.	1 Yes 2 No Hospital: 1	XInpatient 2 ☐ ER/Outpatier	nt 3 DOA Other: 4 Nursing H	lome 5 Residence	6 ☐Other (Specify)	
0	ding Pl h. After th funeral		27. Manner of Death 1. SNatural 5 ☐ Pending (M.	te of Injury 28b. Time o	f 28c. Injury at Work?	28d. Describe how in	ury occurred	
<u>s</u>	endi sath. or: A he fu	ati	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
Ž	l or Attendate after death Director:	Certification:		ce of Injury - At home, farm, still liding, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)	
	urs all		On Continu	h- h				
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical	(Check only 2 Medical Examiner: On the	the best of my knowledge, deat basis of examination and/or in anner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	o, and due to the cause( orred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)	
	o the ithin 2 o the ample	Med	29b. Signature and title of centifier	annor stated.	29c. License number	29d. D	ate signed (Month, Day, Year)	
	FSFO		MM. W		467 60	6	12712004	
	1		30. Name and address of person who completed ca	tuse of death (Item 23a) (Type	Print)	140	1-112	
	6		M. SAEED KONLAR	= 7243 HAN	Print)  JOVER PKW. GREE	SELT I	20770	
	St	ate	31. Date filed (Month, Day, Year) 32	Registrar's Signature	1	,	, , ,	
	Regist		項語 m 7 2000 5	June 19	Ana. V.			

State of Maryland / Department of Health and Mental Hygier

			Certificate of Death		0001	01011
			Decedent's Name (First, Middle, Last)	2. Date of Death	g. Nó.	3. Time of Death
	Physicia	n	ANNA MARIA WILKERSON	JULY C	Day Y	fear 5' 30 pm
100	/Medica		4a Fecility Neme (If not institution, give street and number)  4b. City, Town, or		4c. County of	Death
ممر	Examine	er		THORE	4	110
	- Francisco		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth	5	Birthplace (State or Foreign
	Funeral Director		217-84-4997 1 M 201F 40 Yrs. Months Days Hours Min.	(Month, Day,	1943 A	Country)
	· ·	F	Usual Residence of Decedent	1001.011.	700	- Ca Jenery
	show		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	the Maryis	ģ	MARYLAND NIA BALTIMORE	CITY	/	1.2(Yes 2□No
	n the M	<u>ē</u>	10e. Street end Number 10f. Zip Code		g. Citizen of Wh	et Country?
	hwiti 3a o	Funerai Director	4007 OSWEGO COURT 212K	5 1	45	A
	deat me 2	ē	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race -	American Indian,
0	affar a		Armed Forces?    Married   Armed Forces   If Yes, specify Cuban, Mexican, Puerl	to racan, etc.)		White, etc.
8	Surs.	٥	3 Widowed 4 Divorced Year or Detes:		Specify:	BLACK
21215-0020	within 72 hours aftar death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	\$	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work)	deign 1	6b. Kind of Busin	ness/Industry
2	thin thin	ᇍ	Elementery/Secondary (0-12) College (1-4or 5+)		6	1 17
	or th	ၟႄ	11 H GRADE HOMEMAKER		OWN	HOME
pu	a la la la la la la la la la la la la la	Be Completed		me (First, Middle, M	_	
<u>ya</u>	Mental Mental Mrked o	၉	JAMES WILKERSON KAY	<i>F</i> ,	BAR	KSDALE
Maryland	S ma		19e. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Re			
	end ealth n 27	L	DARIUS WILKERSON (BROTHER) 747 WESTHILLS!			
ore	ges 1 if iter or oth		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	Oc. Location - Cr	ty or Town, State
Ĕ	Peg nant int: i	-1	4 Donation 5 Other (Specify) KING MEMORIAL PARK!	7-10-04 6	JOODL	AWN, MD.
Baltimore,	port	1	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility	BROWN	JR Fi	UNERAL HOME
œ	8 9 E E 8	1		NAVE.	BNITA	MP 21217
		-	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	c or respiratory arre	st,	Approximate
No. of Street, or other Persons	Physician		snock, or neart failure. List only one cause on each line.	•	,	Interval Between Onset and Death
المري	/Medical		Immediate Ceuse (Final disease or condition resulting in death)  e. END STAGE Acquired Immerse d	Chicery !	syde-	e !
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68760	g physicien end es the buriel-trar	edical	Ceuse (Disease or injury that initiated events resulting in death) Lest  Due to (or as a consequence of):			
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	s tha	اج	Motofoloceal connegues.			
D	quire en si	8	,	24a. Wes an perform		24b. Were autopsy findings available prior to completion of cause
ပ္ထ	s be	Del			S.	completion of cause of death?
æ	The lew sate has to pege 2 s	Completed		1 Vet	20 No	1 ☐ Yes 2 ☐ No
Division of Vital Records,	certificate irector, peg	e E	25. Was case referred4o medical 26. Place of Dea	ath (Check only one	)	
$\leq$	Physician: this certific ral director,	0	examiner?	lome 5 ☐ Resider		(Specify)
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Ö	ath. After e fun	읉	1 ☑Neturel 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
<u>S</u>	Atte	<u>ë</u>	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number	or Rural Route Number,
Ö	d in d	i e	building, etc. (Specify)	Chy or Yours,	Olale)	
	To the Mospital or Attending Phys within 24 hours after death. To the Funeral Director: After this complately filled in by the funeral director.	edicai Certification:	29a. Certifier 11V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place			
	n 24 n 24 ne Fu	ğ	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	irred et the time, da	e and place, end	due to the cause(s)
	To the Vithin To the Coming Co	Σ	29b. Signature and title of certifier 29c. License number	29	d. Date signed (	Month, Day, Year)
		,	D17537		(-6	-07
	18	-	30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)	4.0 A	0 11.	7.19-17
			30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)  OALSHAN, S. SALVAMD (600 W. MOUNT 6.)	It we	· Mall	10 2121/
	State	e	31. Date filed (Month, Day, Year) 32 Registrar's Signature			
	Registra		111 0 7 2004 Proces & Angele			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month Year **Physician** Yari 2004 11.04 PM 16 June /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Roland Park Place Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 17, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🛛 F 214-20-4067 93 Director 1910 Pennsylvania Usual Residence of Decedent filed within 72 hours efter death with the Maryland Hygiene.

The trans 23a or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "neturel", or items 23a or 28e-f sho treumstic event, the Medical Examiner must be notified at MD 1√∏ Yes 2□ No Director Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 830 W. 40th Street 21211 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: white þ 3X Widowed 4 ☐ Divorced Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health end Mental Hygient Important: If item 27 is marked other than eny Injury or other treumatic exceptions. stenographer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Robert Small Allison Evelyn Mae Hibner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Backer/friend 402 Cedarcroft Road Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State/ 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Emeral Service Licensee Ronald S. Wade Di Baltimore, MD 21201 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical della reunia **Examiner** Due to (or as e consequence of) Examiner The law requires that the death certificete be executed ate has been signed by the attending physician and page 2 should be deteched for use es the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part.II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ 1No 3 ☐ Probably 4 ☐ Unknown elmenge à 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed certificate 1 Tes 2 1 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident or Attendent efter deat Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital c within 24 hours el To the Funerel D completely filled i 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) In Isabelle V D13657 all mo 20 30. Name and eddress of person who completed cause of death (Ikem 23a) (Type, Print)

MARGREGOR, 830 W. 404 STREET, BALTITURE, DOD 21211

32. Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

0 6 2004

Please Type or Print in B k Indelible Ink. Assure All Copies Are State of Marylans, Department of Health and Mental Hygien Reg. No. U D Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician 4.40AR 2004 コロレ SIDNEY ZACKON /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner MULTI MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 9/19/1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M 2□ F Months Days Hours Min Yrs. 219-22-2821 MARYLAND Director Usual Residence of Decedent pernit. Pages 1 and 2 should be illed within 72 hours after deeth with the Maryland Depertment of Health and Mantel Hyglane. Important: If Item 27 is marked other than "naturel", or items 23s or 28e-f show eny injury or other traumatic event; the Madical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD BALTIMORE TOWSON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 AIGBURTH ROAD APT. 414 21286 USA Funera 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 1 Married 3aitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify \$ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12TH GRADE SALES MANAGEMENT EPSTEIN'S DEPT. STORE 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 2 MORRIS ZACKON GOLDIE ZENNICK 19a. Informant's Name/Reletionship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 AIGBURTH ROAD APT. 414 TOWSON, MD MARGARET ZACKON WIFE 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/3/04 METRO CREMATORY, INC. CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Forth. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Finat disease or condition resulting in death) /Medical ADVANCED PARKINSONIS DISEASE YEARS Examiner Due to (or as a consequence of) DEMENTIA 1EDRS Examin the death carifficate be axecuted been signed by the attending physician end should be detached for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 24 No 1 ☐ Yes 2 ☐ No Attanding Physician: 25. Was case referred to medical examiner? å 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2년 No 2 To the Hospital or Attanding Phys within 24 hours after death.

To the Funerel Director; After this completely illied in by the funeral dil 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JUNE 2nd 2004 Spup Je MD DO053156 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

State

Registrar

SIAKUNMACA

JUL 0 7 2004

31. Date filed (Month, Day, Year)

GUPTA MD POBOX 6303

32 Registrer's Signature

ELLICOTT CITY 140 21042

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup>2004 July **Physician** 2, Helen Allen 6:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Millennium Health & Rehab. Ctr. Baltimore N/A Months Days Hours Min. 8. Date of Birth (Month, Day) Year) Mar. 4, 1920 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Country) **Funeral** 1 M 2 X F 84 216-24-1905 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.
sent if items 23 a rate of other than "natural", or items 23a or 28a-f show and it is the confine than "natural", or other traumatic event, its Madicial Examinate must be notified at 1 Yes 2 No Completed by Funeral Director MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1303 North Lakewood Avenue 21213 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White If Yes, Give Year or Dates: Specify: 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) N/A College (1-4or 5+) None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Unknown ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Bernice Cunningham/Agt. 1303 N. Lakewood Ave. Balto. MD. 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July Date 9 20c. Location - City or Town, Stete 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Baltimore, MD. 2004 MT. Carmel \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility alvin L. Williams Funeral Service .0. Box 11651 Baltimore, MD. 21229 Calvin L P.O. Box P.A. Low 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mhmia **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to animediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) the detached 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ØUnknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed3 1 🗌 Yes 2 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗀 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28b Time of 28d. Describe how injury occurred After 1 Matural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No the within 24 hours after death To the Funeral Director: Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ballimore · HHME 21 11 Ecilain 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 08

**ORIGINAL** 

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	Sta		31. Date filed (Month, Day, Tear)	La Nogis	a .	6	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 3.15 PM Charles Thomas 2004 Bolton July /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital North a lon Burnie Arundel Anne ARUNDEL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreigr Country) **Funeral** 1**X** M 2 ☐ F Months Days Hours 214-54-8617 Director 10/18/1949 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad other than "natural; or Itams 23a or 28a-f sho other traumatic evant, It a Medical Evanti ar must be trofilled at 1 ☐ Yes 2X No Director MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2746 Norfen Road 21227 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes ¾☐ No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk Office Supplier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of Charles E. Bolton Phyllis Mae Cosand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health itam 27 i Phyllis Mae Bolton / mother 8367 W B & A Road Severn, Maryland 21144 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ₹ = 1 X Burial 2 Cremation 3 Removal from State July 8, 9 Department of Important: If any injury or once. Glen Haven Mem. Park ' 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 2004 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Singleton Funeral Home, P.A. Mark Glen Burnie, MD 21061 ancur MO1357 1 Second Ave. SW 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Priysician Icoholi cole /Medical Due to (or as **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Be Completed rentension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examinar? 1 Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attanding 5 Pending investigation Injury s after death death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗍 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

within 24 hours a To the Funaral C

State Registrar

JUL 0 8 2004

29b. Signature and title of certifier

600 Crain Hwy

and manner stated

29d. Date signed (Month, Day, Year) 2004

Name and address of person who completed cause of death (item 23a) (Type, Print)

610, Glan Burnie, MD 21061

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Month Year 05:43AM Die ne mann 2H 2004 /Medical Balking te City

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

May 13, 19 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner City 7. Age (In yrs. last birthday) Johns 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 220-42-6020 1 € M 2 □ F 63 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner neat by notified at Md. Anne Arundle 1 ☐ Yes 2 No Pasadena Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Dover Rd. 21122 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐XYes 2 ☐ No If Yes, Give 1964–67 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: White permit. Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygiene. important: If Itam 27 is marked other than "natural;, any injury or other traumatic event, the Medical France. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Law Firm Attorney 12 + 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles E. Bienemann Katherine Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Bienemann - Brother 13006 Talisman Rd., Reisterstown, Md. 21136 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metro Crematory <sup>1</sup> 4 □ Donation 5 □ Other (Specify) July 8, 2004 Baltimore, Md. 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21117 11605 Reisterstown Rd., Owings Mills, Mo Approximate Approximate Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Distress Syndrone Respiratory Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 20 No 1 Yes 2 No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Diractor: At 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) North Jolfe 21287-9106 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

			1 - For AMEND ITEMS 23A, 27, 28A	aryland Meed Cei	853,0770878 tificate of Dea	լիչոթd Mental Hy ath	giene Reg. No.) () () ()	
			Decedent's Name (First, Middle, Last)			2. Date of De.	ath CUU	3. Time di Death
	Physici: /Medic		GLORIA	В	RICKER	APRIL	29 2004 Year	1:20 P M
}	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca	ation of Death	4c. County of Dea	th
			HOWARD COUNTY GENERAL HOSPI 5. Social Security Number 6. Sex 7. Ag		COLUMBIA  If Under 1 Year   If U	Inder 24 Hrs. 8 Date of Bird	HOWARD	41-1
	Funeral Director		5. Social Security Number 6. Sex 7. Age 130-07-4227 6. Sex 7. Age 1 1 M 2 17 F	e (In yrs. last birthday) 83 Yrs.		ours Min. 8. Date of Bin (Month, Da	19, Yeer) 9. Bir 021	thplace (State or Foreign ountry)  NEW YORK
	D		Usual Residence of Decedent			02/20/1	721	
	anylar show	_	10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	ecto	MD HOWARD  10e. Street and Number	COLUMBIA	10f. Zip Code		10g. Citizen of What C	XX
	with 3a or	Funeral Director	6500 FREETOWN ROAD #216		21044		•	ountry :
	death ms 2:	nera	11. Marital Status  12. Was Decedent   Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispani	ic Origin? (Specify Yes or No		
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. od other than "natural", or items 23a or 28e-f show event, it a Medical Examinar must be notified at	by	1 Never Married 2 Married 1 Yes, Give X 1 Yes, Give X Year or Dates:		v	exican, Puerto Rican, etc.)	Specify: Wh	HITE
5-0	natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during	nost of working	16b. Kind of Business	/Industry
121	filed within Hygiene. ther than ont, It a Mar	duic	Elementary/Secondary (0-12) College (1-4or 5	HOMEM	DO NOT use retired)		OWN HOME	
	Hygie other	a	17. Father's Name (First, Middle, Last)	1101121		Mother's Name (First, Middle,		
/lar	should be filed within of Mental Hygiene. marked other than matic event, it a M	To B	BENJAMIN	KUBERT	Υ	ETTA	UNKN	NOMK
Maryland	2 should and Men is marke reumatic		19a. Informant's Name/Relationship (Type, Print)			lumber or Rural Route Number		Zip Code)
	is 1 and 2 should of Health and Mer item 27 is marke other treumatic		LAWRENCE BRICKER / SON  20a. Method of Disposition	6542 20b. Place of Dispo	CARLINDA AV	E. COLUMBIA	MD 21046 20c. Location - City or	Town State
Baltimore,	Page: ment o ant: if ury or		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	BETH	EL or other place)	05/02/2004	WOODBRIDGE	, N.J.
Bal	permit. Departr Imports any nj	10	21. Signature of Funeral Sprice Licensee	89	00 REISTERS	Facility SOL LEVINS TOWN RD. PIKE	SVILLE, MD	21209
1			23a. Part1. Enter the disease, or complications that ceused shock, or heart failure. List only one cause on each lir Immediate Cause (Final		A	ch as cardiac or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a consequence of):	ial Isdai	MIG		10min
	Examiner		Ather		Cardiovas	cular Diseas	e	YEARS
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	icate be executed physicien and s the burial-transit	Examiner	that initiated events	a consequence of):	placement	-surgical re	VISION	Bomin
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Вох	death certifica e attending ph id for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No □ Unknown the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
P.0	at the de by the tached	hys	9 Unknown					
	es tha igned be del	by P	Part II. Other significant conditions contributing to death b	_ i	nderlying cause given in I		obacco use contribute to	
ord	w requir been si should	ted	HIP FRACTURE	avetallune		101	Yes 2X No 3 P	robably 4 ∐Unknown
Vital Records,	The lavate has	Completed	HIP PRACTURE				an 24b. Were at prior to death? 2 2 No 1 □ Yes	utopsy findings available completion of cause of
Vita	Attending Physicien: Thr death. c death. ector: Atter this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?		Other	Place of Death (Check only o		
of	ig Phys ter this neral dii	.: To	27. Manner of Death 28a. Date of Inju (Month, Da)		IL SLI DOA   41	Nursing Home 5 ☐ Residence Property See 1 Nursing Home 28d. Describe h	dence 6 □Other (Spe now injury occurred	cify)
ion	ttending I death. ctor: After y the funer	atior	Takatural 5 ☐ Pending (Month, Day 2 XAccident investigation 10/28/20		Work? √N M 1 ☐ Yes	2 XNo SUBJEC	T FELL	
Division	ei or Attences efter death	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injurior building, etc.	ury - At home, farm, str c. (Specify) <b>HOME</b>	eet, factory, office	28f. Location (S City or Tow FLUSHIN	Street and Nursber 29 vn, State) 75–29 IG NY 11366	1671HUSTREE
	To the Hospitei or Attenwithin 24 hours efter deati To the Funerel Director: completely filled in by the	Medical (	29a. Certifier (Check only one)  1 Certifying Physicien: To the best 2 Medicel Examiner: On the basis of and manner sta	of my knowledge, death examination and/or in				
	To the To the Comp	Σ	2. Signature and title of certifier	Deputy	29c. License num	nber	29d. Date signed (Mont	
•	10		tanjusting-MD	ME	D314	73	April 30	2004
			30. Name and address of person who contributed cause of department of the particle of the part	eath (Item 23a) (Type,	Print) ck Core u	Day Elliat C	ity, MD =	
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 0 3 2004  32. Registr.	ar's Signature	Sparks			

			1 - For Amend Item 18 Registrar	State of M Per FH,	laryland / Dep 333,07/13/	artment of l	Health and <i>Death</i>	Mental Hy	/giene Reg. Na	2004	21319	
P	hysicia	an	1. Decedent's Name (First, Middle, Las	t)	<del></del>			2. Date of D Month	Da	Year	3. Time of Death	
· Mar.	/Medic Examin		Roy E. B 4a. Facility Name (If not institution, give Union Memorial Ho		)	4b. City, Town, Baltimo	or Location of Dea	July	40.	4c. County of Death N/A		
	ineral rector				ge ( <i>In yrs. last birthday</i> ) 79 Yrs.	If Under 1 Year Months Days		. (Month, D	ay, Year)	9. Birth Cou	place (State or Foreign intry) yland	
death with the Maryland	a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Baltimor	e	10c. City, Town or Lo						10d. Inside City Limits 1 ☐ Yes XXNo	
with the	be not	Director	10e. Street and Number	_		10f. Zip Code			10g. Cit	izen of What Cou	intry?	
ter	ral', or itams 23a or 28a-1 show Examiner must be notified at	by Funeral	11200 Ridgeway Av  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	enue Sout  12. Was Decedent Armed Forces'  1 📉 Yes 2 🗆 If Yes, Give Year or Dates:	Ever in U.S. 13.	21093 Was Decedent of lif Yes, specify Cub 1□ Yes 2☒ No	Hispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or Note Rican, etc.)		14 Race - Ameri Black, White Specify: Whi	can Indian, , etc.	
72	d other then "naturel", avant, It e Medical Ex-	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) Coltege (1-4or	(Give	DO NOT use retire	during most of wo	orking	16b. K	nd of Business/Ir	ndustry	
Maryland 2 d 2 should be filed th and Mental Hygi	2 6	To Be C	17. Father's Name (First, Middle, Last) George Wesley B				Mary I		May	Hoover		
Mar nd 2 sh lith and	~ ~		19a. Informant's Name/Relationship (7 Mrs. Frances Bond	ype, Print)			and Number or R					
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)										cation - City or To		
Baltimo	Importa any inju once.		21. Signature of Funeral Service Licens	£-/	87	Name and Address Name Address N	ess of Facility Lo	ring By	ers I	Funeral 1	DirectorsIn 1133-4784	
Exar	physician and the private transit the private transit	dical Examiner	if any, leading to immediate cause. Enter Underlying	a. pulm  bue to (or as  b. System  bue to (or as	a consequence of):	nyper-		nse s	_	rome	Approximate Interval Between Onset and Death Quecks  Quecks  Amerika	
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ords, P	been signed b	ed by Ph	Part II. Other significant conditions co	ntributing to death t	out not resulting in the u	nderlying cause giv	ven in Part I.		obacco u Yes 2		he cause of death?	
								24a. Was auto perfo 1XYes	psy ormed?	24b. Were auto prior to co death? 1 \( \text{Yes}	psy findings available mpletion of cause of	
	s certif directo	To Be	25. Was case referred to medical examiner?  1   Yes 2   No	Hospital:	ent 2 ☐ ER/Outpatien	t 3 DOA Oth		ath (Check only o	-	i □Other (Specif		
C guill	Atter th tuneral	Certification; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		28c. Inju	ry at	28d. Describe			<i>y</i> )	
Division  To the Hospital or Attendition 24 hours after death	To tha Funaral Diractor: completely filled in by the		3 Suicide 6 Could not be determined	building, e	ury - At home, farm, str c. (Specify)			City or To	wn, State)			
a Hosp	a Funa letely fi	edical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exam	iner: On the best and manner st	of my knowledge, death if examination and/or invaled.	occurred at the tile restigation, in my o	me, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) date and	and manner as si place, and due to	tated. the cause(s)	
To th within	comp	Me	29b. Signature and title of certifier  Ammalows	sky, m	D					9d. Date signed (Month, Day, Year)  July 6, 2004		
	X		30. Name and address of person who c Angela mislousk	amathiad souss of		Print)	-Kway Y	Baltima	. ער	mp 21	218	
A	Stat Registra	e	31. Date filed (Month, Pay, Year)	32. Registr	rar's Signature	Spark	1		- 1	- XI		

		1 = For State Registrar		State o	of Mar	yland / D		t of H	lealth a	ind Me	R	eg. Nø.	0 <b>915</b> 16.	21320		
Physicia /Medic Examin	al	1. Decedent's Name (First, Mic ROBERT 4a. Fecility Name (If not institu Northwest Ho	BR ion, give si						Location of		2. Date of Dea Month	4c. Co	Year 2004 ounty of Dee			
Funeral Director		5. Social Security Number 438–54–6478 Usuel Residence of Decedent	6. Sex	M 2□F	7. Age (	in yrs. last birth Yı	day) If Under		If Under 2 Hours	Min.	B. Date of Birth (Month, Day 08/19/1	Year)	9. Bir	thplace (State or Fore ountry)		
the Maryland	ector	Md         Balt           10e. Street and Number	•		1	Oc. City, Town	ille	2 1						10d. Inside City Limi		
urs a	by Funeral Director	4704 Marykno	1: arried	2. Was Dec Armed Fo 1 □ Yes If Yes, Gi Year or D	2X No	er in U.S.	10f. Zip 212  13. Was Deced If Yes, spec	208 lent of Hi	spanic Orig n, Mexican, Specify:	in? (Speci Puerto Ri	ifv Yes or No-	U.S		erican Indian, te, etc.		
filed within 72 ho Hygiene. ther than *natur ent, the Missical	e Completed	15. Decec (Specify only hig Elementary/Secondary (0-12 6 17. Father's Name (First, Midd	est grade	ation completed) College (	1-4or 5+)	(9	ecedent's Usua Give kind of wor ife. DO NOT us rpenter	rk done d se retired	furing most )			Cons	of Business			
2 should be and Mental le marked o eumatic eve	To Be	Charles Brox	ham	e, Print)		19b. N	Mailing Address	(Street a	Ali	ce Kı	night			Zip Code)		
permit. Pages 1 and 2 should Department of Health and Mer Importent: if Item 27 ie marke any injury or other treumatic once.		Charles Broxl 20a. Method of Disposition 1 Burial 2 Crematic 4 Donation 5 Other 21. Signature 1 Funeral Servi	n 3 □Re (Specify)		State	20b. Place of D cemetery, Druid R	idge Ce	ne of ther place mete d Addres	ery 0	7-09- Lori	-2004 ng Byer	Balti s Fui	imore imore neral	Town, State  Directors  land 21133		
ate be nysicia he bu	licai Examiner	Icai Exam	ical exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. c. d.	Due to	(ur as a c	onsequence of) onsequence of)	•							
death certific e attending p id for use as	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23		ointh 2 D nant at tim	pregnancy Fetal death	3 ☐ Ectopic pre					23d	. Date of del Month	ivery Day Year		
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Physician: The law r this certificate has be ral director, page 2 sh	Be Completed	25. Was case referred to mediexaminer?									Check only on	ed? No	prior to death?	1		
to the negation or attending projection: the within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Certification: 10	1 Yes 2 No  27. Manner of Death 1 Natural 5 Peni 2 Accident inves 3 Suicide 6 Cou	ing tigation	28a. Dite (Mon.	of Injury	ear) 28b. Tim Inju	M M	Sc. Injury Work 1  Y	at	0 280	5 ☐ Resider  d. Describe hor  Location (Str.	w injury oc	ccurred	cify)  oral Route Number,		
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within To the comple		29b. Signature and title of certification of the ce	, J	ne	LLA	m.0	29c.	License O V	number	D	29			Day, Year)		
State Registra	9	MORTHWEST 31. Date filed (Month, Day, Yea	HESP!	TAL	egiştrar's	Signature	RANDA!	LS TI	11.54	MO	711	33.				

			1 - For Stete Registrar	tate of Marylan		artment of tificate o			giene	21221
		М	Decedent's Neme (First, Middle, Last)					2. Date of Dea Month	th Dey Year	3: Time of Death
	Physici /Medic		Thomas Brinster					June	26 2004	8:46 A <sup>M</sup>
	Examin		4a. Fecility Name (If not institution, give street			-	, or Location of D		4c. County of Dee	oth
		a.	149 Nunnery Lane 5. Social Security Number 6. Sex		last high day	If Under 1 Ye	Baltimor			imore
r	Funeral Director		5. Social Security Number 6. Sex 1 № M	7. Age (In yrs. 58	Yrs.	Months Day		Min. 8. Date of Birth (Month, Day) Aug. 16	(Year) 9.81	thplace (State or Foreign ountry)
	-		Usual Residence of Decedent	30				Aug. 10	), 1945 Ma	ryland
	how		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Ba-fs	cto	MD Baltimo	re	В	altimor	e			1 ☐ Yes 2 X No
	ith th	Funeral Director	10e. Street and Number			10f. Zip Code		1	log. Citizen of What C	ountry?
	s 23s	rai		ot A6	0 100	Mar Dan L	21228	0./0	United St	
	item item	-un	11.11.11.11.11.11.11.11.11.11.11.11.11.	Was Decedent Ever in U. Armed Forces? 1 □ Yes 2X No	.5.	f Yes, specify C	uban, Mexican, P	? (Specify Yes or No- ruerto Rican, etc.)	Bleck, Whi	
980	urs af	by		If Yes, Give Year or Dates:		l□Yes 2 <b>X</b> □N	lo Specify:		Specify: Wh	ite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or items 23s or 28s-f show int, the Madical Examiner must be netified at	Completed	15. Decedent's Education (Specify only highest grade co		16a. Deced	dent's Usual Occ	supation ne during most of	working	16b. Kind of Business	/Industry
2	ithin 10.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	OO NOT use ret	ired)	Working		
	lygier her th	Cor	12			Transpo		Name (Class Add differen	Floral	
ano	ntal F	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle, I	,	
Ž	hould d Me mark matic	오	John Brinster  19a. Informant's Name/Relationship (Type,	Print)	19h Mailir	n Address /Stre		aret Kelly or Rural Route Number		Zin Code)
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic avent, the Macical Examinat mast be notified at Once.		Dr. Jim Brinster Ne					Edgewater		
	s 1 ar f Hea item other		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other p	ven br.,		20c. Location - City or	
Baltimore,	Page nent o nt: If ry or	1	1 ☑Burial 2 ☐ Cremation 3 ☐ Remo	Jvai irom State			netery 7	-7-2004	Baltimore,	MD
alti	permit. Departminents imports any injuinents.		21. Sprature of Funeral Service License	About 1 bors	01 22	. Name and Add	dress of FacilityA	mbrose Fun	eral Home,	Inc.
<b>m</b>	805 50	1	William Will	SUN PILL	58/ 13	28 Sulpl	nur Spri	ng Rd., Ar	butus, MD	21227
Н			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as the complex of the com	ons that caused the deatl ause on each line.	n. Do not ent	er the mode of d	lying, such as car	diac or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Laryna	eal	Canc	er		^	Onset and Death
top:	/Medical Examiner		resulting in death)	Due to (or as a consec	uence of):					4.
		-	Sequentially list conditions, b. —	Dua to (or as a consequ	dance off:					
	uted d ansit	Examiner	if any, leading to infriediate cause. Enter Underlying Cause (Disease or injury that initiated events							
o Î	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as a consequ	uence of):					
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Icai	d	51						
9	artifica ing ph e as tl	Med	fF FEMALE:	20						
Вох	leath certifi attending a for use as	Physician/Med	23b. Was decedent pregnant up the past 12 months?	If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetel	death 3	Ectopic pregnar			23d. Date of de Month	fivery Day Year
0	the a	ysic	1 Type 2 TNo	4∐ Pregnant at time of de 9∐ Unknown	eath 5∟	Other (specify)				
<u>а</u>	res that the de igned by the be detached	Ph	Part II. Other significant conditions contrib	uting to death but not resi	ulting in the ur	iderlying cause	given in Part I.	23e. Did tot	bacco use contribute to	the cause of death?
Records,	uires sign lid be	d by	Diabetes Helli	as Ture	T			1 <del>2 1</del> 7 6	es 2 No 3 P	robably 4 Unknown
<u></u>	w requir s been si should	iete		(1				24a. Was a	n 24b. Were au	utopsy findings available
	Fhe la te has age 2	Completed						autops perform	ned? prior to death?	completion of cause of 2 □ No
ţ	ian: rtifica stor, p	0	25. Was case referred to medical				26. Place of	1 ☐ Yes 2 Death (Check only on		2010
Division of Vital	or Attending Physicien: The law requires that the interfer death. Diffector: After this certificate has been signed by the in by the funeral director, page 2 should be detached.	To B	examiner? 1 Yes 2 10 Hosp	1   Inpatient 2	ER/Outpatien	t 3□ DOA	Other: 4 🗆 Nursin	ng Home 5 Areside	ence 6 Other (Spe	cify)
n C	Ing P	on:	27. Manner of Death 2  1 Aatural 5 Pending	8a. Date of fnjury (Month, Day Year)	28b. Time of Injury	28c. In W		28d. Describe ho	ow injury occurred	
Sio	Attending r death.  actor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				□Yes 2□No	- COV. 1 (O)		
$\leq$	I or Attendate after death Director:	Certification;	4 Homicide determined 2	<ol> <li>Place of Injury - At he building, etc. (Specif)</li> </ol>	me, farm, stro /)	et, factory, offic	:0	City or Town	reet and Number or Ri n, State)	ural Houte Number,
_	To the Hospital within 24 hours a To the Funaral I completely filled	ai C	29a. Certifier 1 Certifying Physicia	nn: To the best of my kno	wledge, death	occurred at the	time, date and ni	lace, and due to the ca	ause(s) and manner as	stated.
	n 24 h	edical	(Check only 2 Medical Examiner:	On the basis of examinat and manner stated.	tion and/or inv	estigation, in m	y opinion, death o	occurred at the time, da	ate and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifies			29c. Lice	nse number	25	9d. Date signed (Mont	h, Dey, Year)
			7 mule len	motion	mr	D50	588		7/1/04	ł l
	0		30. Name and address of person who compl	eted cause of death (Item	23а) (Туре,		,		- 1	1
	X		29 South Pay Years	Ka Str	eet	Balt	more	MD	21201	
Qr.	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa						

# e.

			. For	State of Ma	aryland	/ Depa	artment of H	ealth and M	1ental Hy	/giene	9	
		•	Stata     Registrar			Cei	tificate of l	Death		Rag. No	2004	2   322
			1. Decedent's Name (First, Middle, La	ist)			-		2. Date of D	eath Da	y Year	3. Time of Death
	ysicia Nedica		Alvin Arlie Ba	astin					DE	25		16:15 PM M
	amine	er	4a. Facility Name (If not institution, given Speculate 145877) 60	re street and number)	St		4b. City, Town, or BIRTI HUR	Location of Death  MdZIZ	30	40	c. County of Dear	th
Fun Dire	eral ctor		512-18-1890	5ex 7. Ag 1ĂM 2□F 84	e (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D Jan. 3	irth lay Year , 192	9. Bird Co Kans	hplace (State or Foreign untry) 385
pu *		-	Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation					10d. Inside City Limits
Maryla a-f shov	Medat	tor	Maryland Howard		Toc. City,	TOWN OF LO	Colu	mbia				1 Yes 21 No
r 28g	Tale of	<u>ie</u>	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Co	ountry?
h wit	2 2	<u>=</u>	8614 Cobblefield	Drive Apt	1-G		2104.	5		1	U.S.A.	
72 hours after death with the Maryland natural; or Items 23a or 28a-f show	zaminacmu	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 🖄 Yes 2 🗆 If If Yes, Give Year or Dates:			Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2⊠ No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: Wh	e, etc.
d within 72 hours afi giene. er than "natural", or	- 58 ·		15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	dent's Usual Occupa	ation during most of work	ing	16b. K	(ind of Business	Industry
filed within Hygiene. ther than	N S	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		t Instru			US	Air For	ce
d 2 should be filed within th and Mental Hygiene.	ic event,	To Be C	17. Father's Name (First, Middle, Las Harvey Bast:	-				18. Mother's Name Edith H		e, Maider	n Sumame)	
should nd Men	teur	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street a	and Number or Rur	al Route Numi	ber, City	or Town, State, 2	Zip Code)
	other traumatic	- [	Michael Bastin-	Grandson		1070	4 Cordac	e Walk Co	lumbia	. Ma	rvland 2	21044
of Health item 27	othe		20a. Method of Disposition		20b. Pla	ce of Disno	sition (Name of natory or other place		Date	-	ocation - City or	
			1 ☐Burial 2 ☐ Cremation 3 [  4 ☐ Donation 5 ☐ Other (Special Control of the Cont					"Park6/30	/2004	Gre	eensbord	, NC
permit. Page Department Important: fi	in ei		21. Signature of Funeral Service Lice	nsee		22	. Name and Addres	ss of Facility Cha	rles S	7.0	iler & S	Son
Ped E	any ir		Jessuer ?	Hoge				rn Avenue				
			23a. Part Enter the disease, or conshock, or heart failure. List only			Do not ent	er the mode of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
Physic /Med	_		disease or condition resulting in death)	a	63PIR		y FAILUR	E				3 MONTHS
Exami	_			Due to (or as			ACCIDEN	UT				6 Horithis.
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Dua to (or as	а сопвадие	nea of):	190		Λ.			
kecuted	al-transit	xamlner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. HRTERIOS	CLERET	TIC CAS	210 LIREBIA	20 VASCULA	WZ 1)	13EOK	5 =	3 YEAR25
, o	Ξ	×	resulting in death) Last	Due to (or as	a conseque	nce of):	1					L

IF FEMALE:

3 Suicide

4 - Homicide

29b. Signature and title of certifier

23b. Was decedent pregnant

in the past 12 months?

1 Yes 2 No
9 Unknown

а	RESPIRATORY FA	LUITE		3 Mew 7/15
b.	Due to (or as a consequence of):  CEREPRO VIASCULAR ACC	LIDENT		6 Horithis.
С.	ALTERIOSCIETE TIC CARIO E	REBROVASCULAR	DISENSE	34EA125
·.	Due to (or as a consequence of):			1
d.				

within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physiciar completely filled in by the funeral director, page 2 should be detached for use as the burit Be Completed by Physiclan/Medical E

Medical Certification: To

Division of Vital Records, P.O. Box 68760

MEVIL

BASTIN

To the Hospital or Attending Physician: The law requires that the death certificate be

3 □Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. KENTL FAILURE DEPENDENT VEN TILATOR

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ thinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

23d. Date of delivery

Day

Year

Month

25. Was case relerred to medical examiner? Hospital: 1 Anpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA

1 Yes 2 🗆 No 1 Yes 2 No 26. Place of Death (Check only one)

28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation

6 Could not be determined

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number 29d. Date signed (Month, Day, Year) De1346

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HID LLUIVERSITY SPECIALTY 439 TITL ST. BACTIMEDE NA 31. Date filed (Month, Day, Year)

State Registrar

1

0 8 2004

			1 - For State Registrar	State o	of Marylar	-		t of He		Mental Hy	giene	21323
			1. Decedent's Name (First, Midd.	e, Last)						2. Date of D		3. Time of Death
	Physicia /Medic			Olga	Mary	C.	lift			July	Day Yes	5:50 A M
>	Examin		4a. Facility Name (If not institutio	n, give street and nu	ımber)		4b. City,	Town, or Lo	ocation of Deat	h	4c. County of D	eath
			Ivy Hal	1				ltimor	~e		Bal.	timore
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ <b>X</b> F	7. Age (In yrs.	**	If Under Months		f Under 24 Hrs Hours Min.	(Month, D	rth ay, Year) 9.1	Birthplace (State or Foreign Country)
	Director	ļ	176-16-0285	1 M 2 LNF	8:	3 Yrs.				Nov. 2	5, 1920	Austria
	and w		Usual Residence of Decedent  10a. State 10b. County	,	10c. Cit	ty. Town or Lo	ocation					10d. Inside City Limits
	sho	ъ				,						1 ☐ Yes 2 🕱 No
	the N	ect	Maryland Balt 10e. Street and Number	imore		Balti	nore 10f. Zip	Codo			10g. Citizen of What	
	with a or			al Count				1220			U.S.A	
	leath	era	34 Congression	1	edent Ever in U	.S. 13.	Was Dece	dent of Hisp	anic Origin? (S	pecify Yes or N		merican Indian,
10	r Iter	Funeral Director	1 Never Married 2 Mar	ried Armed Fo	2 📉 No		If Yes, spec	cify Cuban,	Mexican, Puer	to Rican, etc.)	Black, W	hite, etc.
215-0036	72 hours after death with the Maryland netural', or Items 23a or 28a-f show Iteal Examiner must be molified at	by	3 XWidowed 4 ☐ Divorced	If Yes, Gi Year or D	ve Dates:		1 ☐ Yes	21XI No	Specify:		Specify:	White
2-0	72 hc	sted	15. Deceder	it's Education st grade completed)	1	16a. Dece	dent's Usua	al Occupation	on ing most of wo	rkina	16b. Kind of Busine	ss/Industry
2	within ene. than "	npie	Elementary/Secondary (0-12)	College (		life.	DO NOT us	se retired)	ing mode or mor	Na i g		
21	filed w Hygier thar th	Completed	12			Cafe	eteri		nager			Co. Schools
P	ba fil ita! H d otl	Be	17. Father's Name (First, Middle,					18	3. Mother's Nar		e, Maiden Surname)	
yla	ould ba Mentat sarked o	2	Adam Beno						Emma	<u>Geli</u>		
Maryland	ges 1 and 2 should be filed within 72 hours attar death with the Marylar nt of Health and Mental Hygiene.  If itam 27 Is marked other than "netural", or Items 23e or 28a-f show or other traumatic svent, the Woolcal Examiner must be notified at		19a. Informant's Name/Relations								oer, City or Town, State	
	1 and 2 Health am 27 I		Ronald W.  20a. Method of Disposition	Clift S	0 <b>n</b>	34 CO			al Cour	T Balt	imore, Mary	
ğ	in of h		1 ☑ Burial 2 ☐ Cremation		State Du	laney	Valle	ther place)	-			
Baltimore,	t. Partmer		' 4 ☐ Donation 5 ☐ Other (5			Memor	ial_Ga	ardens			Timonium	Maryland
Bal	permit. Page Department o Important: If any Injury or once.	Щ	21. Sign to Pon srvice	Censee				d Address	L.		son Funera <sup>-</sup> Maryland	Home, Inc. 21204
	11 11		23a. Part1. Enter the disease, o	complications that	caused the deat	1000						Approximate
	Physician		shock, or heart failure. List Immediate Cause (Final									Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)		ardiac a		ımı a_					
	Examiner			Athe	Koocle	Mohic	Core	mary	Ax	ery D	isesse	un-Known
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conseq	juence of):						
	cate be axecuted oblysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	C								
o,	axe an ar urial-t	EX	resulting in death) Last	Due to	(or as a conseq	uence of):						
3760,	ate be nysici he bu	cai		d								
39	leath certifical attending phy I for usa as th	Med	IF FEMALE:	T .						-		
Вох	ith ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?		itcome of pregna birth 2  Feta		⊒Ectopic pr	egnancy			23d. Date of a	delivery Day Year
-	adea the at	sici	1 Yes 2 No	4□Pregi 9□Unkn	nant at time of d	leath 5	Other (sp	ecify)			Month	Day 1 ear
P.O.	The law requires that the death certificate to has been signed by the attending phys age 2 should be detached for use as the	Physician/M	Part II. Other significant conditi	One contributing to d	loath but not roo	sulting in the w	ndorking o		o Dort I	23e Did	tobacco uso contributo	to the cause of death?
JS,	signe d ba d	Completed by	Advanced	A A A		Dem			HTN			Probably 4 Minknown
oro	w requir been si should	etec	Dicker	Gaite					()   / 4	/		
Records,	elaw hast aa2s	npl	Laveres,	Gove	r					24a. Was	s an 24b. Were prior to death	autopsy findings available o completion of cause of
										1 ☐ Yes	2 No 1 Y	
Vit	ysician: The law is certificate has t director, paga 2 s	Be	25. Was case referred to medica examiner?	Hoppitale						ith (Check only		
of	ding Phys th. After this funaral dir	<u>۲</u>	1 Yes 2 No	1	Inpatient 2	ER/Outpatier 28b. Time o		)A			idence 6 Other (S	pecify)
2	ding h. After funa	tion	1 Natural 5 Pendin		of Injury oth, Day Year)	Injury	м	8c. Injury at Work?	2 🗌 No	200. 0030.100	now injury occurred	
Si	Attanding Physician: r death. actor: After this certifics by the funaral director, I	ica	3 Suicide 6 Could	not be	e of Injury - At h	ome farm sti				28f. Location	Street and Number or	Rural Route Number
Division of Vital	if or A after Dirac	Certification;	4 Homicide determ	build	ing, etc. (Specif	(y)	eot, lactory	, once		City or To	wn, State)	ricial ricotte riciniber,
	ospita hours inaral y filled		29a. Certifier 1 Certifyii	ng Physicien: To the	e best of my kno	wledge, deat	h occurred	at the time,	date and place	, and due to the	cause(s) and manner	as stated.
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	fedical	one)	and man	ner stated.	ition and/or in				rred at the time,	date and place, and d	``
	To To Con	Σ	29b. Signature and title of certifie	- M.D .				License n		5/1	29d. Date signed (Mo	
	1-		1445					リー	JO 7	ノヿ	07-03	5-2004
	5		7	SASCEM	· 70		AST	BRA	BL	VD.	07 - 09 $MD - 2$	1221
	Sta Registr		31. Date filed (Month, Day, Year,	2004	Registrar's Signa	Ture L	-					

**Funeral** 

Director

filed within 72 hours after death with the Maryland ed other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at Director Funeral Completed by Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other treumatic event, tha M Be

Maryland 21215-0036

Baltimore,

**Physician** /Medical Examiner

permit. Page Department of Important: If any injury or once.

the attending physician and hed for use as the burial-transit signed by the a need has page 2 certificate funeral director, this After To the musping after death.
within 24 hours after death.
To the Funerel Director: Aft

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

For State Registrar 1. Decedent's Name (First, Middle, Last) July 2004 6:30 ам ď4 Campbell Guy Μ. 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Lutherville 1703 Notre Dame Ave. 8. Date of Birth (Month, Day, Year) OCt. 13, 1920 If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 X M 2 □ F 83 Virginia 233-26-7968 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 1703 Notre Dame Ave. 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 MYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 € Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Industrial Machinist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Bessie Rogers Herman William Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Lois Campbell/ Wife 1703 Notre Dame Ave. Lutherville, Md. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Leeds Cemetery 7-7-04 Markhan, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Uneral Hote, 1050 York Rd. Towson, Md. Approximate Interval Between Onset and Death r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobecco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 2 No Certification; To 1 🗌 Yeş 2 ER/Outpatient 3□ DOA 28b. Time of 27. Many r of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Whaturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 120688

Registrar

State

Fairmon

30. Name and ad as of person who completed cause ath (Item 23a) (Type, Print)

man

MD

32. Registrar's Signature

-wed

31. Date filed (Month, Day, Yeer)

		1 - For State Registrar	State of	Marylan		artment of rtificate o		and Mer		iene	001	0.1
1		Decedent's Name (First, Middle,	Last)						Date of Deat	h E	004	3. Time of Death
Physicia /Medic		Audrey				Ca	rev		Month July 4	Day 20	04	1:05 pm M
Examin		4a. Facility Name (If not institution,	give street and num	ber)			, or Location o			1	ounty of Death	
		Greater Baltimo	ore Medica	1 Cent	er	Towson				Ва	1timore	
Funeral Director		5. Social Security Number  214-46-8550  Usual Residence of Decedent	6. Sex 7 1 ☐ M 2 <b>X</b> ☐ F	7. Age (In yrs. 58	last birthday) Yrs.	If Under 1 Year Months Day		24 Hrs. 8. Min. 07	Date of Birth (Month, Day,	Year) 45	Cou	place (State or Foreign ntry) IA
and and		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation			-			10d. Inside City Limits
death with the Maryland me 23a or 28e-f show r must be notified at	호	MD NA		Bal	timor	e						1 XYes 2 □ No
r 28e	Director	10e. Street and Number				10f. Zip Code	•	-	10	og. Citize	n of What Cou	ntry?
h witi		505 East Cold	aspring I	ane		21	212			U	.S.A.	
дея дея	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.	.S. 13.	Was Decedent o	f Hispanic Orig	gin? (Specify	Yes or No-	14.	. Race - Americ Black, White,	
hours efter turel', or ite	by Fu	1 Never Married 2 Marrie	ed 1 Tes 2	No N <b>X</b> I	1	1 ☐ Yes 2 🔀 N			,	Sı	necify:	
hours turei',		3 Widowed 4 Divorced	Year or Dat	les:	16a Dagg	doet's Havel Oss	unation		and a		E	Black
filed within 72 ho Hyglene. yther than "natur ant, the Medical	Completed	15. Decedent' (Specify only highest	grade completed)		(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne during most red)	of working	ļ	IBD. KING	of Business/In	dustry
with lene.	mo	Elementary/Secondary (0-12) 12th grade	College (1-	4or 5+)		s Aid	,			Bus	Servi	ice
Hyg othe	Bec	17. Father's Name (First, Middle, L	ast)				18. Mothe	r's Name (Fi	irst, Middle, N	faiden Su	ımame)	
uld be Aenta rked tic ev	To B	John E. Carey	7				Alet	ha Ma	e Dou	gla	ss	
and N		19a. Informant's Name/Relationsh	ip (Type, Print)	iahter	19b. Mailir	ng Address (Stre	et and Numbe	r or Rural Ro	oute Number,	City or T	own, State, Zip	Code)
pes 1 end 2 should be filed within of Health and Mental Hygienal Hygiens if item 27 is marked other than "it other treumatic event, in a hear		Annteria Rodo	ers-Feri	сетт	000 E	East Co						
of H of H or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 Removal from S	tate 20b. P	lace of Dispo emetery, crer	sition (Name of matory or other p	lace)	Date	2	20c. Loca	tion - City or To	own, State
Pages Iment of tent: If it jury or o		`4 ☐Donation 5 ☐ Other (Sp	ecify)		_	norial			'04 F	land	allsto	own, Md
permit. Pages 1 Department of H Importent: If Ite any Injury or ot once.		21. Signature of Funeral Service L	icensee	1	Ma	Name and Add	H Wes	t				
40244		Jala	Mare	wood the deat	43	300 Wab	ash A	ve, B			Maryl	and 21215
Pnysician /Medical		23a Part1. Enter the disease, or shock, free theart failure. List of the theart failure. List of the theart failure is a sease or condition resulting in death)	_ a	ch line.	5	01 010 11000 01 0	yilig, suom as v		spiratory arre			Interval Between Onset and Death
Examiner	Jer	Sequentially list conditions, if a ry, leading to min addate cause. Enter Underlying Cause (Disease or injury	b. Due to (o	Meta rasa consec	Stan	c hu	15 C	anc	ev			
rate be executed physicien end the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (o	r as a conseq	uence of):						_	
cate be physicie the bur	dical		d.									
	ledi											
The law requires that the deeth certificate has been signed by the ettending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		th 2□Feta nt at time of d	death 3	Ectopic pregnar Other (specify)				230	d. Date of delive Month	ery Day Year
that the de the by the c	Ph.	Part II. Other significant condition	ns contributing to dea	ath but not res	ulting in the u	nderlying cause	given in Part I.		23e. Did tob	acco use	contribute to the	he cause of death?
ulres sign	d by	March of the and							1 🗌 Ye	s 2 🗆 N	No 3 □ Prob	pably 4 Anknown
w requir been si should	Completed			-					24a. Was an	. 2	24h Were auto	psy findings available
The larate hes	mc								autopsy perform	ed?	prior to con death?	mpletion of cause of
	e C	25. Was case referred to medical				-	26 Place		1 ☐ Yes 2 heck only one	No No	1 🗌 Yes	2100
S 5	0 0	examiner? 1 ☐ Yes 2 ② No	Hospital: 1 1 1	patient 2	ER/Outpatier	nt 3 DOA	Ther				Other (Specifi	iv)
. თ • •	n:T	27. Manner of Death	28a. Date of		28b. Time of	28c. In		4 4	Describe ho			,,
Attending r death.	atio	1 Natural 5 Pending	ation	, buy rous	injury		□Yes 2□N	No				
tel or Atte s efter de al Directo ed in by th	Certification;	3 Suicide 4 Homicide 6 Could not be determined 6 Homicide 7 Homicide 7 Homicide 7 Homicide 7 Homicide 7 Homicide 7 Homicide 7 Homicide 7 Homicide 7 Homicide 7 Homicide 7 Homicide 7 Homicide 7 Homicide 8 Homicide 7 Homicide 8 Homicide 7 Homicide 8 Homici								Al Route Number,		
To the Hospitel or Attendin within 24 hours effect death. To the Punerel Director: Alt completely filled in by the fun	edical	29a. Certifier t Certifying (Check only one)	Physicien: To the base examiner: On the base and manner	sis of examina	wledge, death tion and/or in	n occurred at the vestigation, in my	time, date and opinion, deat	d place, and th occurred a	due to the ca	use(s) an te and pla	d manner as st ace, and due to	tated. the cause(s)
To the To the Comp	M	29b. Signature and title of certifier	, ,	1 N			nse number	21/-			igned (Month,	
6		> C-8Ma									5/04	
17		30. Name and address of person v		of death (Item	23a) (Type,	Print) - Charl	14 ST	F. BO	uto	200	ne Mi	021203
Sta		31. Date file Month Day, Year) 200	4 32. Re	gistrar's Signa	ture	1					_	

DHMH 17 Rev 1/2001

ORIGINAL

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY 05 Day **Physician** STEVEN COSNER 1:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD COUNTY 611 LACEWOOD DRIVE **EDGEWOOD** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1**∑**M 2□F Months Days 42 215-82-1049 Yrs. Director July 28 1961 West Virginia Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show ust be notified at Md. n/a Baltimore Director 1 ¥Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ö 21230 U.S.A. 1826 Byrd Street Itams 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. traumatic evant, the Medical Examiner: of filed within 72 hours after de I Hygiene.

Other than "natural", or Itam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 XNo Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Telemarketer Marketing 8 0 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fit h and Mental H 7 Is marked oth Be Effinger Cosner Edith Nelson ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Itam 27 Is any injury or other trau Nancy Mobberly (Sister) 2625 E. Joppa Road, Baltimore, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Storm Cemetery 07/09/2004 Mt. Storm. W. Va. \* 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home P.A 21. Signature of Funeral Vivice Licens 130 E. Fort Ave. Baltimore, Md. 21230 Art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Circhosis Priysician resulting in death) /Medical Due to (or as a consequence of) Examiner Hepatitis C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 No Division of Vital tha Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 4□ Nursing Home 5□ Residence 6 To ther S resid. examiner? Hospital: 1 Inpatient Other: 1 ☐ Yes 2 TNo this 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide within 24 hours a To tha Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title 29c. License number 29d. Dane signed (Month, Day, Year) pely 06, 2004 1)53517 mendon 30. Name and address of person who impleted calle of death (Item 23a) (Type, Print) 301 Suint Paul Place Bultonore Mayland 21202 ARNEL MENDOZALAGLEHD 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 0 8 2004 Registrar

USHMAN

			1 - For State Registrar	State of Ma	aryland / Dep		of H	ealth an	d Mental H	lygiene Reg. No		21329
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last Constantinos     Aa. Facility Name (If not institution, give 4225 Darnall	Cou	rtalis			Location of D	2. Date of Month July	Day 4,	2004 County of Deal	3. Time of beauty 6:25 P M imore
	Funeral Director		5. Social Security Number 6. Se		e (In yrs. last birthday, 73 Yrs.	If Under 1		If Under 24	Hrs. 8. Date of (Month, Dec.	Birth Day, Year) 12,193	Q Rid	hplace (State or Foreig nuntry) LLCL
	the Maryland 28a-f show notified at	rector	10a. State 10b. County  Maryland Baltimo  10e. Street and Number	re	10c. City, Town or L	Baltin				10a. Citiz	zen of What Co	10d. Inside City Limits 1 □ Yes 2 ▼ No
36	s after death with , or items 23a or	by Funeral Director	4225 Darnall Roa  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	d  12. Was Decedent   Armed Forces? 1  Yes 2	Ever in U.S. 13.		nt of His y Cubar	21236 spanic Origin' n, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No- 1	U.S.A.  14. Race - Ame Black, Whit	ncan Indian, e, etc.
id 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it a Maxical Ext. oil at that be notified at injury or other traumatic event, it a Maxical Ext. oil at that be notified at e.g.	Be Completed b	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 12th Grade  17. Father's Name (First, Middle, Last)	cation	+)	dent's Usual a kind of work DO NOT use taway	it Oi		working Name (First, Midd	Sela	nd of Business/ 6-Emplo taurant Sumame)	yed
, Maryland	1 and 2 should be filed with Health and Mental Hygiene. Iem 27 is marked other thar other traumatic event, It e. N	ToB	Nicolaos Cour 19a. Informant's Name/Relationship (T) Mrs. Antonia Court		<u>del</u> 4225	Darno	ell i	nd Number o	r Rural Route Nun Baltimor	e, MD	Town, State, 2	
Baltimore,	permit. Pages 1. Department of He Important: If Iten any injury or oth		20a. Method of Disposition  1 X Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens			trios 2. Name and	Cem. Address	7/7 s of Facility S	Date 1/2004 Schimunek	Balt Fune	ral Hon	Maryland
	Pnysician /Medical		23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each lin	the death. Do not en	ter the mode	of dying	, such as car	Baltimo diac or respiratory	arrest,	7 21236	Approximate Interval Between Sheet and Death
,097	Ite be executed XX XX XX XX XX XX XX XX XX XX XX XX XX	ical Examiner	Sequentially list conditions, in the sequential sequence of the sequence of th	Due to (or as	a consequence of):							
O. Box 68	death certifica e attending ph d for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	⊒Ectopic preç ⊒ Other (spec				. 2	3d. Date of deli Month	very Day Year
S, J	The law requires that the ste has been signed by th page 2 should be detache	by	Part If. Other significant conditions co.	ntributing to death bu	ut not resulting in the u	nderlying cau	ise giver	n in Part I.				the cause of death?
		e Completed	25. Was case referred to medical					26 Place of	24a. Wa aut pei 1  Yes	opsy formed? 2 No	24b. Were au prior to death? 1 \(\sum \) Yes	topsy findings available ompletion of cause of
ō	ng Phys fter this neral dii	sation: To B	27. Mann Death  1 Autural 5 Pending 2 Accident investigation	lospital: 1 □ Inpatie 28a. Date of Injur (Month, Day			Other	- 4 □ Nursin at	g Home 5 💢 Re 28d. Describ	sidence 6		ify)
Š	Hospital or Attendii 24 hours after death. Funeral Director: A tely filled in by the fu	al Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined	building, etc	of my knowledge, deat	h occurred at	the time	o, date and pl	City or T	own, State)	and manner as	ral Route Number,
	To the Hospital or a within 24 hours after To the Funeral Directory completely filled in biggins.	Medical	(Check only 2   Medical Examione)  29b. Signature and fittle of Certifier	ner: On the basis of and manner sta	examination and/or in ted.	vestigation, in	License	nion, death o	ccurred at the time	e, date and p	place, and due	to the cause(s)
	Sta Registr		John Downs m.D.  31. Date filed (Month, Day, Year)  JUL 0 8 2004	7505	OS/Er Dr		37 1/	owsor	mD	210	204	501

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. Ne. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day CRONIN 10:10 AM EANOR JULY 7 200 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. April 4, 1931 Hopkins Hospital N/A Johns 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 218-26-5005 73 Director Yrs Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other treumatic event, If a Medical Examiner must be normal and once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Harkord Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2024 Furnace Road 21047 U.S.A. Be Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Puklewicz Rose Vincent Kolodiie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John Cronin (husband) 2024 Furnace Rd., Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 7/11/2004 Baltimore, Maryland 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, In
610 W. MacPhail Rd., Bel Air, MD 27014 21. Signature of Funeral Service bicensee 10 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. shock, or heart failu Immediate Cause (Final Onset and Death Physician adenocavcinoma disease or condition Droncho genic years resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed obstructive 2 No 3 Probably 4 □Unknown Dulmonary 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical

the Hospitel or Attending Physicien: The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. certificate has this funeral After after death. Director: 24 hours a

Be 2 Certification:

Medical

completely

the within

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26. Place of Death (Check only one) examiner? 1 ☐ Yes 2'XNo 1.XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

Other 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

000

Wolfe St Baltimore, Maryland

2004

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year)

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hristopher Ho HMann Johns Hontains

31. Date filed (Month, Day, Year) State Registrar JUL 0 8 2004 32. Registrar's Signature

			1 - For AMEND ITEM #10 Registrar	State of Marylan	3 / P/8/ Cei	rtment of F 04 TAS tificate of	lealth and Death	Mental Hy	giene Reg. No.	2004	21331	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Alfred Cookman Col	lins Jr.				2. Date of De Month July	Day	Year 2004	3. Time of Death	
	Examin		4a. Facility Name (If not institution, give s Carroll Hospital (	Center		Westmins				ounty of Deet arro11	h	
	Funeral Director		5. Social Security Number 6. Sex 218-03-5106	7. Age (In yrs. 86	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		v, Year)	9. Birt Co Md	hplace (State or Foreign untry)	
	Maryland -f ahow	tor	10a. State 10b. County Md Howard		y, Town or Lo Ellicot	cation					10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	3a or 28a	Funeral Director	10e. Street and Number 3106 Evergreen Wa	ıy		10f. Zip Code	21042		10g. Citize	en of What Co	untry?	
920	n 72 hours after death with the Maryland "naturel", or Itema 23a or 28a-1 ahow calcal Executer mark by notified at	by		2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Λ Year or Dates:	1	Was Decedent of H	lispanic Origin? (San, Mexican, Puer	Specify Yes or No to Rican, etc.)	14	Race - Ame Black, White pecify: Whi	e, etc.	
Maryland 21215-0036	d within piene. r than "	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) 12	cation completed) College (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done DO NOT use retired IChinest	during most of wo	rking		ns Mac	chine Co.	
yland	s 1 and 2 should be filed f Health and Mental Hygis Item 27 is marked other other traumatic event, III	To Be (	17. Father's Name (First, Middle, Last) Alfred C. Collins	Sr.				me (First, Middle, Eleanor		,		
	Health and tem 27 is my tem 27 is my other traum		19a. Informant's Name/Relationship (Type Eleanor Janice Col	lins (daughte	r) 310		een Way,	Ellicot	er, City or i t Cit	y, Md	(ip Code) 21042	
Baltimore,	Page ment o ant: If ury or		20a. Method of Disposition  1 ☐ Burial 2 【X Cremation 3 ☐ Ri  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, cren L Count	sition (Name of natory or other place y Cremat	ion 7-8-		Sykes	sville,	Md	
Balt	Departition Depart		21. Signature of Funeral Service License  Parge Harget	- Herbert	22 F	. Name and Addre	<sup>ss of Facility</sup> Ha 195 Syke	ight Fun sville,	eral Md 21	Home & .784	Chapel	
>	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death e cause on each line.	n. Do not ent	er the mode of dyin	ng, such as cardia	or respiratory ai	rrest,		Approximate Interval Between Onset and Death	
ı	Examiner	-	Sequentially list conditions b	Due to (or as a consequence of the consequence of t							,	
60,	ate be executed hysicien and the burial-transit	cal Examiner	Cause (Disease or injury that mittated events resulting in death) Last  Due to (or as a consequence of):									
P.O. Box 68760,	death certific e attending p id for use as t	Physician/Medlc	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[ Yes 2 \] No 9 \[ Unknown \]	Gc. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3	Ectopic pregnancy Other (specify)	1		23	d. Date of deli Month	very Day Year	
Ś	es pe	by	Par II. Other significant conditions con Rictor Produmo		ulting in the ur	nderlying cause giv	en in Part I.	23e. Did to			the cause of death?	
of Vital Record	The law ete has b page 2 s	Completed						24a. Was autop perfo		prior to death?	topsy findings available completion of cause of	
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	ER/Outpatien	t 3 DOA Oth	ac-	ath (Check only o		Other (Spec	u(hv)	
ion o	ding h. After fune	atlon; T	27. Manne of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	y at	28d. Describe h			.,,,	
Division	Hospitel or Attent     A hours after deatl     Funerel Director:     Funelel prector:     Felled in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (8 City or Tox	Street and I vn, State)	Vumber or Ru	ral Route Number,	
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director:	edical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examin	ician: To the best of my knower: On the basis of examination and manner stated.	wledge, death tion and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occu	, and due to the	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)	
5	To the twithin 2. To the to complete	W	29b. Signature and title of certified	M m		29c. Licenso	e number		29d. Date	signed (Month	Day, Year)	
L	Val	2/	30. Name and address of person who con	OM, sendsu	114 B-	esites (	ntr Priv	a Reizh	Blom	mo	21136	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 8 2004	32. Registrar's Signa	ture Spo	nes					_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrat MEND ITEM #2 PER OHY G833 7 Partificate of Death 2. Date of Death Month JULYDay Time of Death 03 Yea 2004 **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign **Funeral** 1□M 212F Months Days 214-50-077 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or items 23a or 28e-f show the Medical Exercities at 1 ☐ Yes 2 🗹 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Race - American Indian Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 
Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental DREAMA HAW WHI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 92 Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State Pages permit. Pages Department of Importent: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Furthern Service Licens 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena MD, 21122 Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, disease shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 2years Colon adenscaransmo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Feta! death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 2 🗆 No ate has been signed by the a page 2 should be detached? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate 1 ☐ Yes 2 🗖 No the funeral director, 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Anatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hord 20 402 1974 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** MARSHA 3:09 PM LOUISE COSNER Juli 03 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PASADENA ANNE ARUNDE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min 214.52.785 1 M 2 F Yrs. Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show treumatic event, the Medical Examinar must be molified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Battimore, Maryland 21215-0036 Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any injury or other treumatic event, the Medica 9008. Elementary/Secondary (0-12) College (1-4or 5+) TOMEMAKER 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) SIMON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) DAUGHER 105 MULBERRY AVE. PASADENAMO. ZIIZZ STAL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Pemoval from State \* 4 □ Donation 5 □ Other (Specify)

I. Signature 2 Fureful Service Upensee ULY 12, 2004 1 Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRONIC Physician OBSTRUCTINE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner ig physician and as the burial-transit The law requires that the dea h certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 99 COLITIS 1 Probably 4 Unknown UDO MEMBRANOUS 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 s 24a. Was an autopsy performed? OSTEOPOROSI 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No Division of Vital Hospitel or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 1 ☐ Yes 2 ☑No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural hours after death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) yd ni beliil 4 - Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) markinskim D54574 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLEN BURNIE MD 21061 1412 NORTH MARKM.S. Kim, MD CRAIN HWY GA 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 0 8 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 3 PM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ente Baltimore Itaibor MOS Dita If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 9. Birthplace (State of Country) Days Hours 1 M 2 F Min. 245-56-361 65 Yrs Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other then "naturel", or items 23a or 28a-1 show other treumatic event, the Medical Examinar must be notified at Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent F Armed Forces? 11. Marital Status ver in U.S Hispanic Origin? (Specify Yes or No-ban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married TYes 2 N No Baltimore, Maryland 21215-0036 Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "en yi hjury or other treumatic event, If a Med gone. College (1-4or 5+) Professiona 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilson mant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. 1 Warial 2 ☐ Cremation 3 Removal from State 7-10-04 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Vaugho C. Greene Fuheral Source Koad Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failude. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 40card DMINUTE, /Medical Due to (or as a consequence of) Examiner onar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed as the burial-transit Due to (or as a the attending physician Box 68760 Physiclan/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown 合 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 No To the Hospital or Attending Physicien: director 25. Was case referred to medical Be 26. Place of Death (Check only one examiner Other: ٩ 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. After Injury at Work? 1 Natural Injun 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Direct 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and use to the cause(s) and manner as stated.

■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

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ORIGINAL

eath (Item 23a) (Type

32. Registrar's Signature

			51.4	artment of Health and Menta	al Hygiene Reg. N2 0 0 4 2 1 3 3 5				
	Physic /Medi Examir	cal	MILLE QUICK DICKEY		te of Death onth Day Year 5:40/4 M  4c. County of Death				
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F C Yrs. last birthday) Usual Residence of Decedent	BA / HINNE   If Under 24 Hrs.   8. Dat	te of Birth onth, Day, Year)  9. Birthplace (State or Foreign Country)  15. 26, 1943  MD				
	death with the Maryland ms 23a or 28e-f show must be notified at	Director	10a. State 10b. County 10c. City, Town or Lo	10f. Zip Code	10d. Inside City Limits 1				
36	or ite	by Funeral	17	Was Decedent of Hispanic Origin? (Specify Yelf Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☐ No Specify:	es or No- etc.)  14. Race - American Indian, Black, White, etc.  Specify: Black				
21215-0036	"net	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired)  Frich EA	16b. Kind of Business/Industry  School System				
Maryland	ges 1 and 2 should be filed within to f Health and Mental Hygiene. If item 27 is marked other than or other treumatic event. The Mental treumatic event.	To Be (	17. Father's Name (First, Middle, Last)  Suffue Stat Six Six Six 19a nformant's Name/Relationship (Type, Print) 19b. Maillin	g Address (Street and Number or Rural Route	Middle, Maiden Sumame)  40 // E  Number, City or Town, State, Zip Code)				
Baltimore, N	jes 1 and of Health If item 27 or other tr		1921  20a. Method of Disposition 1	CLESTVIEW Red Bayfind  sition (Name of natory or other place)  Memocral  Name and Address of Facility  BEHS	20c. Location - City or Town, State  Ballimone MD				
Balt	permit. Pag Department Importent: any injury o			29 N. CARILINE 5+ BA	Approximate Approximate				
8760, \	/Medical Examiner physician and the pritial-transit	al Examiner	Jmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying cause. (Chease or your) that initiated events resulting in death) Last  a. Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):		Interval Between Onset and Death				
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detachad for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 4 □ Pregnant at time of death 5 □ 9 □ Unknown	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year				
ط	w requires that s been signed b should be deta	ted by Pr	Part II. Other significant conditions contributing to death but not resulting in the un  multiple Sclevsis	iderlying cause given in Part I. 236	a. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown				
of Vital Records,	ilclan: The law i certificate has bu rector, page 2 sh	Be Comple	Respect Failme with were examiner?	4040	24a. Was an autopsy performed? prior to completion of cause of death?  1 24b. Were autopsy findings available prior to completion of cause of death?  1 24c. Was an autopsy findings available prior to completion of cause of death?				
Division of V	ling Phys a. After this funeral di	Certification; To f	1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury 2 Accident investigation	28c. Injury at Work?  M 1 Yes 2 No	□ Residence 6 □Other (Specify) scribe how injury occurred				
Divi	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier	City	ation (Street and Number or Rural Route Number, or Town, State)				
	To the Hos within 24 h To the Fur completely	Medical	29b. Signature and title of certifier	estigation, in my opinion, death occurred at the  29c. License number	o time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)				
)	$\sigma_{j}$		30. Name and address of person who completed cause of death (Item 23a) (Type, F	05-65-08 Print) 41416RONG SI	Try 4, 2004				
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature  JUL 0 8 2004	Baltimo, m	D 21212 Q				
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DHMH 17 Rev 1/2001

QUICK-DICKEY, LILLY

For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUL Y **Physician** Daniel Joseph Dregier, Sr. 7,2004 10:35AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 28, 1924 Baltimore 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F 79 Yrs Director 217-12-3609 Maryland Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at Director 1 ☐ Yes 2 ☑ No Mď. Baltimore Lutherville 10e, Street and Number 10f. Zip Code 10g Citizen of What Country? with 1209 Oakcroft Dr. 21093 USA death by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Broker Real Estate +1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Sumame) Joseph F. Dregier Martha Wankowski 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 is m any injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Daniel Dregier, Jr./ Son 2 Quail Cross Ct. Reisterstown, Md. 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Cem. 7–10–04 Baltimore, Md. 21. Signature of Fun r I Service Lice see 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson. Md. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CORONARY ARTERY DISEASE YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐ Pregnant at time of death 5 Other (specify) P.0. the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown CHRONIC RENAL FAILURE Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 2 7 No has DIABETES MELLITIS this certificate 1 ☐ Yes 2 🔀 No To the Hospital or Attending Physician: within &4 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation after death.

I Director: Aft
d in by the fur 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D 27310 0 and address of person who completed cause of death (Item 23a) (Type, Print) 30. Namy EFREY POSNER M. D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 31 Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 8 Registrar

DHMH 17 Rev 1/2001

2004

ILLIAN DORN

	State of Maryland	i / Depa <i>Cei</i>	artment of He	ealth and eath	F	Reg. No.	21338
Physician	1. Decedent's Name (First, Middle, Last) Francis W. Dimick				2. Date of Dea Month July	Day Year 2, 2004	3. Time of Death  9:45am M
/Medical Examiner	4a. Fecility Name (If not institution, give street and number) 2031 #1-C Rudy Serra Drive		4b. City, Town, or L Elders	burg		4c. County of Death	County
Funeral Director	5. Social Security Number 6. Sex 7. Age ( <i>In yrs. la</i> 215−01−8469 1	ast birthday) Yrs.	If Under 1 Year Months Days	Hours M	n. 8. Date of Birt Month, Da March	26, 1917	nplace (State or Foreign untry) MD
D	Toa. State	, Town or Lo	ccation Eldersbur	ρ			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
vith the Mar or 28a-f st be notified be notified	MD   Carroll  10e. Street and Number  2031 Rudy Serra Drive #1C		10f. Zip Code 217			10g. Citizen of What Co USA	untry?
fter death v	11. Marital Status  11. Naver Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces?  11. Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?	s. 13.	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 No		(Specify Yes or No erto Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
ed within 72 hours a vgiene. Per then "natural", o t, the Medical Exar. Completed by	3 Widowed 4 Divorced Year or Dates:	16a. Dece (Give	edent's Usual Occupate kind of work done do DO NOT use retired)	uring most of		16b. Kind of Business	Industry
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, ILE M. To Be Comp	17. Fathers Name (First, Middle, Last)	Te.	levision R	18. Mother's I	an <sub>Name (First, Middle</sub> na Shadt	Repair , Maiden Sumame)	
and Men and Men is marke aumatic	19a. Informant's Name/Relationship (Type, Print)			nd Number o	Rural Route Numb	er, City or Town, State, Sburg, MD 2	
ages 1 and 2 nt of Health I: If Item 27 r or other tri	Mrs. Marie L. Dimick (Wife)  20a. Method of Disposition 1  Purial 2 Cremation 3 Removal from State 1  Donation 5 Other (Specify)	Place of Disp	oosition (Name of Permatory or other place Valley Men	9)	Date	20c. Location - City or Timonium, N	Town, State
permit. Pages Department of Important: If it any injury or o	21. Signature of Funeral Service Licensee		Sykesville	e. MD 2	1784 (410	PEL, PA(Boz ))-795-1400	
Pnysician /Medical	23a. Part1. Enter the disease, or complications that caused the deet shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)  Sequentially list conditions,	h. Do not el	nter the mode of dying	g, such as car	diac or respiratory a	arrest,	Approximate Interval Between Onset and Death
be executed ician and burial-transit and burial-tra	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consection)	querios ory.	lricula	~ 0	ryflu	wa _	1 Minute
The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	al death 3	3 □Ectopic pregnancy 5 □ Other (specify)	1		23d. Date of do Month	Day Year
8 P 9	Part II. Other significant conditions contributing to death but not re-	sulting in the	a underlying cause giv	en in Part I.		tobacco use contribute ]Yes 2 No 3 ☐ F	to the cause of death? Probably 4 \(\_\)Unknow
The law requires t aate has been signe page 2 should be t					24a. Wa aut per 1 □ Yes	opsy prior to formed death	autopsy findings available completion of cause of
certificate	25. Was case referred to medical		Otto		f Death (Check only		anniful.
Byd Sign	1 Yes 2 No	28b. Time Injur	e of 28c. Injury	ry at	28d. Describ	sidence 6 Other (Sp e how injury occurred	өспу
or Attending after death. I Director: After d in by the fune	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spec	city)			City or I	(Street and Number or own, State)	
Hospital 24 hours a Funeral I stely filled	29a. Certifier (Check only one)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kr and manner stated.	nowledge, de nation and/o	eath occurred at the ti r investigation, in my o	ime, date and opinion, death	place, and due to the occurred at the time	6, dato and pizzo, and a	
To the Vithin 2 To the complete	29b. Signature and title of certifier Coffee U	118	29c. Licens	1533	8	29d. Date signed (Mo	nun, vay, Year)
011	30. Name and address of person who complete cause of death (It	8	pe, Print) La Se	alle,	Read	Balto 1	ud 21286
Stat Registra		navore	books				

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM 24A PER VERB, G833,07/08/04/DHB (Certificate of Death Reg. No. 1) Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1 SERT ATHERINE **Physician** 4:30 AM 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Deet 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Franklin Square Millenium If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct 5, 1920 9. Birthplace (State or Foreign Country) New York If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 253 F Yrs. -12-0150 83 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location th and Mental Hygiene.
7 is marked other then "netural", or items 23e or 28e-f show traumatic event, I'm Medical Examiner must be notified at 1♥ Yes 2 No Baltimore Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21223 1217 W. Fayette Street IISA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2X ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: white Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☑ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) restaraunt waitress unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard Sacci ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health a if item 27 ls or other train Rocco Sacci/nephew 20 Longwood Drive Athens, NY 12015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: if any Injury or once. 4 □ Donation 5 ♥ Other (Specify) in statge 21 Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last BYPASE, GRAFT RONANY ARTERY
Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 10THYRIUDISM 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been signed funeral director, pege 2 should be de ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕔 3□ DOA ို 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After Matural 2 Accident 5 Pending investigation 2 □ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RABHAKARMID. 300 ARMORY PLACE BALINDZIZO) MADURA
31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUL 0 8 2004

DHMH 16 Rev 6/95

CPM 04-04208 JOHN ELLIOTT

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registres Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2004 Jüne 11:30 AM NHOT ELLIOTT /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Agnes Hospital Baltimore NIA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Oay, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 150M 2□F 47 216745162 MD Director 1956 Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at BALTIMORE 1 Yes 2 No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with KIRKWOOD ROAD 21207 U.S.A. 1401 items 23c Be Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married I ☐ Yes 2 XNo Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Specify: WHITE Yas, Giva If Yes, Give Year or Dates: 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DISABLED 10th grade 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F Pages 1 and 2 should be ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I 1601 KIRKWOOD RD BALTIMORE MD 21207 MICHAEL GENTILE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/03/04 PIKESVILLE, MD \* 4 □ Donation 5 □ Other (Specify) RIDGE DRUID 21. Jign ture of Fund all personal icen-22, Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICES
5151 BALTIMORE NATIONAL DIKE BALTO MD 21729 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner The law requires fhat the death certificate be executed burjal-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? 1/DYes 2□No or Attending Physician: funeral director. 25. Was case referred to medical examiner?
1 X Yes 2 No Be 26. Place of Death (Check only one. Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA Certification: To this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 5 Pending investigation nours after death.

neral Director: At filled in by the fu 1 🗌 Yes 2 No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 2120 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUL 0 8 2004

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment rtificate			Mental H	ygieni Reg. N	1001	2131.1
	Physic	ian	1. Decedent's Name (First, Middle, Last						2. Date of D	eath Da	V Yea	3. Time of Death
	/Medi	cal	Joseph		Falco						y 5, 20	
	Exami	ner	4a. Facility Name (If not institution, give Saint Joseph  5. Social Security Number 6. Se	Medical	Center			ocation of Dea	son			ltimore
	Funeral Director			X 7. Age ØM 2□F	(In yrs. last birthday) 92 Yrs.	If Under 1 Months	Days	If Under 24 Hr. Hours Min		irth Pay, Year, 12,1	.912 Pe	Birthplace (State or Foreign Country) nnsylvania
	ryland how	١.	10a. State 10b. County		10c. City, Town or Lo	ocation	-					10d. Inside City Limits
	the Marylar 28a-f show	cto	Maryland Baltimor	`e	Tows	on						1 ☐ Yes 2 🕅 No
	with th	Director	10e. Street and Number			10f. Zip (				10g. Ci	izen of What	Country?
	eath is 23	erai	808 Shelley Roa	12. Was Decedent E	vor in II S 12		1286		2		U.S.A.	
36	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. It and Mental Hyglene. 7 is marked other then "neturel", or items 23e or 28e-f show treumetic event. Its Madical Examinar must be nutilized at	by Funerai	1 Never Married 2 Married 3 X Widowed 4 Divorced	Amed Forces?  1 X Yes 2 No of Yes, Give 19 Year or Dates.		was Decede If Yes, specif 1 ☐ Yes 2		Specify:	Specify Yes or N to Rican, etc.)	0-	Black, Wh	
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<u> </u>	should be ind Mental s marked o	To	James Fal 19a. Informant's Name/Relationship (Ty		105 11.11		101	Mari		erri		
Ma	and 2 sho salth and n 27 is ma		James M. Falco	Son		helle)			ural Route Numb			
ē,	- 1 9 E		20a. Method of Disposition		20b. Place of Dispo	sition (Name	a of	iu 10	wson, Ma Date	_	cation - City o	286 or Town, State
E G	a 0 = =		1 □XBurial 2 □ Cremation 3 □ R  `4 □ Donation 5 □ Other (Specify)	emoval from State	Dulaney Memori	Walley al Gar	y dens	i Hulv	9, 2004	Ti	monium	Maryland
Baltimore,	permit. Pag Department Importent: I eny injury o once.		21. Signature of Funetal Service License		uneral							
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused t	he death. Do not ent	050 Your the mode					rand	Approximate Interval Between
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Вох	eath certific attending p	Physician/Me	in the past 12 months?	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti	Fetal death 3	Ectopic preg				2	3d. Date of de Month	elivery Day Year
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٥,		by Pł	Part II. Other significant conditions con	tributing to death but	not resulting in the ur	iderlying cau	ise given i	in Part I.	23e. Did t	obacco u	se contribute t	o the cause of death?
Records,	w requires been sign should be	ed k	CONGESTIVE HEART I	FAILURE					1 🗆 '	Yes 2	No 3□P	robably 4 Unknown
ecc	aw as b	Completed				_			24a. Was		24b. Were a	utopsy findings available completion of cause of
		Con							perfo	rmed? 2 <b>20</b> No	death?	
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ospital: 🏑			Other		th (Check only o			
	Attending Physicien: r death. sctor: After this certific by the funeral director.	1: To	27. Manner of Death	ospital: 1 X Inpatient 28a. Date of Injury	2 ER/Outpatient	and the same	Other: : Injury at		ome 5 Resident			ecify)
o	nding Ph ith. :: After thi e funeral	atior	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day )	(ear) Injury	м	Work?	2 🗆 No	200. 2000100 1	iow injury	occurred	
=	or Attend after death Director: , In by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home, farm, stre (Specify)	et, factory, o	office		28f. Location (5 City or Tox	Street and vn, State)	l Number or R	ural Route Number,
	Hospita 4 hours Funerel ely filled	Medicai C	29a. Certifier 1. Certifying Phys (Check only one)	er: On the basis of e	xamination and/or inv	occurred at lestigation, in	the time,	date and place on, death occu	, and due to the or	cause(s)	and manner as	s stated.
	vithin 2 To the complet	Mec	29b. Signature and title of certifier	and manner state	rd.		icense nu				signed (Mont	
	-3-8		- xayinda ()	mella	m-0			41410		July	osigned (Mon	2 / U U .
11	1	2	30. Name and address of person who cor	mpleted cause of dea	th (Item 23a) (Type. F		\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \	71716		- weg	0 / /	7,04,
1	1		JOGINDER P MEH	Made with a second	7601 OSL		RIVE	TOWSE	N MARY	LANI	2120	14
	Sta Registra		31. Date filed (Month, Day, Year) 200		s Signature	-60						
	- region		0 200	T JAMES MA								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2004 **Physician** Eleanor S. Fonshill /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) County of Death Box Examiner Rosedale If Under 1 Year | If Under 24 Hrs. HOSPITO timoi Franklin Square 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛛 F Yrs. Director 149-28-1982 68 May 29, Scotland Usual Residence of Decedent 10b. County 10c, City, Town or Location 10a. State 10d. Inside City Limits treumatic event, the Medical Examinar rust by notified at 1 ☐ Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 4112 Baker Lane 21236 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 ò 1 ☐ Yes 2 ☐ No Specify: Specify 3 Widowed 4 Divorced and Mental Hygiene. White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Public Schools 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) Be James M. Vallance Jane Stevenson ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a 4112 Baker Lane Baltimore, other t Mr. Ronald L. Fonshill/Husband Maryland 21236 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or \* 4 ☐ Donation 5 ☐ Other (Specify) Hillton Service Corp. 7/9/04 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Preymonia Physician Day /Medical Due to (or as a consequence of): Bleeding **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coagulation The law requires that the death certificate be executed · Disseminated Introvascular burial-tran Due to (or as a consequence of) 569515Box 68760. Completed by Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the detached of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renal 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe 2Z No 1 ☐ Yes 2 ☐ No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2004

JUL 8

Drarif

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sheikh 9000 Franklin

32. Registrar's Signature

Square

29c. License number

D0061104

Drive Baltimore

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1:30 JOHN G. FREELAND /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MEMORIAL HOSPITAI
Number 6. Sex 7. UNTON RAI TIMORE.

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. NA
9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Yrs. 56 Director 216-44-5977 FEB 6, 1948 M) Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location itam 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Madical Examitar roust be notified at 10d. Inside City Limits Director 1 XYes 2 No MD NA BAKTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 ANJUE REUSS COURT 21222 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 AFRICAN 1 ☐ Yes 2 🛣 No \$ Specify: 3 ☐ Widowed 4 ☐ Divorced AMERICAN 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 h and Mental Hygiene. 7 is marked othar than "na Elementary/Secondary (0-12) College (1-4or 5+) 12 INSPECTOR ENGINEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at Important: If itam 27 is any injury or other traugner. JOYCE FREELAND (SPOUSE) 106 BALTIMORE, MD 21222 20c. Location - City or Town, State ANJUE REUSS COURT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) GARRISON FOREST VET. 7/13, 2004 OWINGS MILLS, MD 21. Signature Fineral Service Licensee. 22. Name and Address of Facility Wylie Funeral Home PA 638 N. GILMOR STREET BALTIMORE, MD 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final f nysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YPER PENSIUN Sequentially list conditions, flany Leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 X Natural 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending after death.

Diractor: Aff 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MICHE PAROGAZULAO AT 2438946 July 6, 2004 7 ause of death (Item 23a) (Type, Print) 701 EATT AANIWAY BANAWAE, MD 21218 32. Begistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year July Gladvs Allen Graham 2004 1:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beaverbrook Assisted Living Columbia Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 84 Director 145-07-0523 Yrs New Jersey Auq. 26, 1919 Usual Residence of Decedent the Maryland 10a, State 10b Count 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event. It a Mudical Examinar must be notified at 1 ☐ Yes 2 ENO Directo Maryland Howard Columbia 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 5111 Starsplit Lane 21044 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Itei Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) University of Maryland <u>Secretary</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond T. Allen Ruby Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Cooper - Daughter 5111 Starsplit Lane Columbia, Maryland 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if Ite any injury or otl ang injury or otl 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Berlin Cemetery 7/14/04 Berlin, New Jersey 22. Name and Address of Facility 21. Signature of Euneral Service Licensee Gary L. Kaufman Funeral 7250 Washington Blvd. Home At MMP., Inc. Elkridge, Maryland 21075 Cman 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Non Ima Priysician disease or condition resulting in death) 10 mouths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, loading to min solate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a nonsectioned of): certificate be executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' this certificate 1 ☐ Yes 2 □ No 2 No the Hospitel or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' ASSISTED Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) uni) D38509 11chulas 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10065 Little PATAXENT Pky Columbia MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Brian Griffin Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Brian JULY 3, 2004 3:55 P. /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Social Security Number Birthplace (State or Foreign Country) 10M 20F Months 35 Director October 28, 1968 INK Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28e-f show traumatic evant, the Medical Evantre entrustive notified at 1 1 Yes 2 No Director exmone ND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 Itame 23a Funeral Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ō Baltimore. Maryland 21215-0036 1 ☐ Yes 2 ☐ 10 Specify: by Specify: Blace 3 Widowed 4 Divorced Year or Dates: "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry markad othar than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. abonen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 12 should be fi h and Mental H 7 la markad otl Be Mildr aughn 19a. Informant's Name/Relationship (Type, Wint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 so t of Health an GniPAM ethrone MD 21229 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ita
any injury or ott -. Zvon cen -12-04 4 Donation 5 Other (Specify) 22. Name and Address of 21. Signature of Funeral Service Licenses 207 Tessier 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Multiple gunshot wounds /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit Due to (or as a consequence of): physician Box 68760 pe Physician/Medical as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1. □ Yes 2 □ No 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🕅 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 XYes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospitel or Attanding 5 Pending investigation 1 Natural 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Subject was shot 1 ☐ Yes 2N ☐ No death. 2 Accident after death 6 ☐ Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide City or Town, State)
4400 Block Maybe Hall Red, Arthmore To the Hospitel within 24 hours a To the Funaral D Sheet 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Toushold O.C.M.E. JULY 4,2004 ree. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Tasha Zireenber a.H 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 8 2004 Registrar

				For State of Ma			Health and M	lental Hy	giene	
				Registrar		Certificate o	of Death		Reg. No.	21346
		Physici /Medic		1. Decedent's Name (First, Middle, Last)  Frederick Lee Gray, Jr				2. Date of De Month		ear 04 00/0 AM
		Examir		4a. Facility Name (If not institution, give street and number)			n, or Location of Death	47	4c. County of	
				5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birth		Burnie, M		71,11	Afundel
		Funeral Director		217-12-8846 <sup>1</sup> ⅓ <sup>M</sup> <sup>2</sup> □F		rs. Months Day		8. Date of Bir (Month, Da May 26	y, Year) • 1924	. Birthplece (State or Foreign Country) MD
. ,		land w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
FREderick		r 28a-f show	to	MD Anne Arundel		Glen Burni	le l			1 ☐ Yes 2 🛣 No
v		with the	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	at Country?
2		th witi	ai D	1310 Aster Drive			21061		US	SA
CT.		dea a	Funeral	11. Marital Status 12. Was Decedent Armed Forces?		13. Was Decedent of	of Hispanic Origin? (Speuban, Mexican, Puerto	ecify Yes or No	- 14. Race -	American Indian, White, etc.
. ,	21215-0036		by	1 ☐ Never Married 2 📉 Married 1 ☐ Yes 2 📜 If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 N		1110411, 010.7	Specify:	White
* A	2-0	72 hc	eted	15. Decedent's Education (Specify only highest grade completed)	16a. [	Decedent's Usual Occ	cupation	ina	16b. Kind of Busin	ess/Industry
GRAY	2	C * 3	Completed	Elementary/Secondary (0-12) College (1-4or 5	ō+)	life. DO NOT use ret	ne during most of worki ired)	ng .		
•		a filed within I Hygiene. other than ent, Ine M		17 Fotbodo Namo (First Middle Loct)		Aerospace	Engineer	(F) . A #1 1 W		Contractor
	anc	ntal H ad of	Be	17. Father's Name (First, Middle, Last)					Maiden Sumame)	
	Ž	hould d Mer marka matic	J.	Frederick Lee Gray, Sr.  19a. Informant's Name/Relationship (Type, Print)	10h	Mailing Address (Stm	et and Number or Rura		Pumphrey	
	Ma	nd 2 s Ith an 27 Is trau	1.5	Virginia E. Gray / wife		1310 Aste				
	ē,	es 1 and 2 should be filed of Health and Mental Hygis fitam 27 Is markad other r other traumatic event, II		20a. Method of Disposition	20b. Place of I	Disposition (Name of		Date Du	20c. Location - Cit	yland 21061 y or Town, State
	Baltimore, Maryland	permit. Pages Department of Important: If it any injury or c		1 ☐ Burial 2 🏹 Cremation 3 ☐ Removal from State  * 4 ☐ Donation 5 ☐ Other (Specify)		, crematory or other p peake Crem	July	8, 2004	Stevensv	rilla MD
	a <u>t</u> :	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	- Griebaj	22. Name and Add				Home, P.A.
	B	Depa Impo any is	1. 7	Mark a. Vaneure M	01357	1 Seco				aryland 21061
				23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	i the death. Do no					Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition	Recoil	Patery F	Allure			Onset and Death
		/Medical Examiner		resulting in death)  Due to (or as	a consequence of	n):		_		1
		LXAIIIIIIEI	_	Sequentially list conditions, b. Chronic	_ OBSTR	uctive Pu	Induny D	Seasc		
		be; ist	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	à consaquence of	9.	,			
		icate be executed physician and s the burial-transit	Examin	that initiated events	a consequence of	f):				
	68760,	death certificate be execul e attending physician and d for use as the burial-trai	aiE							
	.89	ificate g phy as the	edicai	0.						
	Вох	eath certifi attending I for use as	/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		0.05-4-3-3			23d. Date of	delivery
	_ 4	death	sicia	1 Yes 2 No 4 Pregnant at	2 ☐ Fetal death time of death	3 □Ectopic pregnar 5 □ Other (specify)			Month	Day Year
	P.0	at the d by the	Physician/M	9 Li Unknown				_		
6	s,	wrequires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death be	ut not resulting in t	the underlying cause	given in Part I.		-	te to the cause of death?
	010	requi	eted					1 <b>-</b> Y	es 2 No 3	Probably 4 []Unknown
	Division of Vital Records,	e lav	Completed					24a. Was autop	an 24b. Wern sy prior med? deat	e autopsy findings available to completion of cause of h?
	E	sician: Th certificate rector, pag	e Co	25. Was case referred to medical			22 21 / 2 /	1 Tes	2 € No 1 □	
	>	Physician: this certific ral director,	To B	examiner?  1 Yes 2 100 Hospital: 1 Inpatie	ent 2 ER/Outp	patient 3 DOA	26. Place of Death	-	ence 6 □Other (	Spanife)
	0			27. Manner of Death 28a. Date of Injur		me of 28c. In			ow injury occurred	эрөспу)
	io	Attending r death. sctor: After by the tune	atio	2 Accident investigation	rrear) inji		ork? ∐Yes 2∐No			
	ivis	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju	ury - At home, farm	n, street, factory, offic	е 2	28f. Location (S City or Tow	treet and Number o	r Rural Route Number,
	Q	ital o irs aft ral Di lled ir							·	<u> </u>
		To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of 2 Medical Examiner: On the basis of and manner sta	examination and/	death occurred at the for investigation, in my	time, date and place, a opinion, death occurre	and due to the ded at the time, o	ause(s) and manne late and place, and	r as stated. due to the cause(s)
		To t To t	Σ	29b. Signature and title of certifier		29c. Lice	nse number	2	9d. Date signed (M	
		$\sim$		Hey t traver no		Do:	27415		July 3,	,2004
		, }		30. Name and address of person who completed cause of de HENRY L. FRANCIS M. D	aath (Item 23a) (T	ype, Print) ARUNZ	al Hospital			
	47	Sta Registr	100		ar's Signature	parks				
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Ŋ			For Stete		State of Ma	•	epartment of F C <i>ertificate of</i>			giene Reg. No. () () ()	
			1. Decedent's Name		st)				2. Date of Dea	ath CUU	3. Time of Death
	Physicia /Medic			Larry	Seth		Griffin		July 1,	2004 Y	0130 A. M
	Examin				street and number)		4b. City, Town, o	or Location of Deat	th	4c. County of I	Death et County
- An		3	5. Social Security N		rille Road	(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs			Birthplace (State or Foreign Country)
	Funeral Director		219-84-8			. 7	rs. Months Days	Hours Min.	6-25-	73	Md.
pur	<b>3</b> (42)		Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Maryla	f sho	tor	Md.	Balti	imore	Owi	ngs Mills				1X Yes 2 No
h the	r 28e	Funeral Director	10e. Street and Nur	nber			10f. Zip Code			10g. Citizen of Wha	it Country?
th wit	23£ c	rai D	271 Owi	ngs Gate		t. 102	21117			USA	
er de	Itams	nne	11. Marital Status	ed 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🛣 N	ver in U.S.	<ol> <li>Was Decedent of H If Yes, specify Cub</li> </ol>	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black, V	American Indian, White, etc.
urs aft	ol', or	þ	3 ☐ Widowed		If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:		Specify:	Black
U C I C I S 10000 filed within 72 hours after death with the Maryland	natur	Completed	(Spec	15. Decedent's Edify only highest gra	ducation de completed)	16a. (	Decedent's Usual Occup Give kind of work done life. DO NOT use retire	oation during most of wo	orking	16b. Kind of Busin	ess/Industry
within	then "	mpi	Elementary/Seco 8th grad		College (1-4or 5-	+)	Laborer	a)		Constr	ruction
# p	Hygic other ent, II	Be Co	17. Father's Name		)			18. Mother's Na	me (First, Middle,	Maiden Sumame)	
should be	Nental rked	To B	Norman		Ca	mpbell		Sandr	a	Gri	ffin
2 sho	ls ma		19a. Informant's Na	me/Relationship (			Mailing Address (Street				
1 and	Health em 27 ther to		Quincie 20a. Method of Disp		Sister		168 Foxwood Disposition (Name of r, crematory or other pla		altimore Date	, Md. 21 20c. Location - Cit	221 y or Town, State
Pages	ant of l		1 X Burial 2		Removal from State		, crematory or other pla 11 Mem. Gar		9-04	Dundalk	, Md.
mit. Pages	Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel, or Items 23s or 28e-1 show up you injury or other traumatic event, the Medical Examinet meat be notified at once.		21. Signature of Fu				22. Name and Addre			ltimore,	
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					plications that caused one cause on each lin	the <del>death.</del> Do n e.	ot enter the mode of dyi	ng, such as cardia			Approximate Interval Between Onset and Death
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ecute	and -trans	Examiner	Cause (Disease or that initiated events resulting in death)		c	a consequence o	f):				
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ortificate be executed	ig phy: as the	ed			2						
ath cer	been signed by the attending should be detached for use a	ian/M	IF FEMALE: 23b. Was deceden in the past 12		23c. If yes, outcome of 1 Live birth	2 🗌 Fetal death	3 Ectopic pregnanc	y		23d. Date o Month	f delivery Day Year
. 9	the a	Physic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□ Pregnant at 9□ Unknown	time of death	5 Other (specify)				
that the	ned by detail	by Ph	Part II. Dther signit	icant conditions	contributing to death bu	it not resulting in	the underlying cause gr	ven in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?
ecords, law requires	en sigr								1 🗆 Y	(es 200 3 E	Probably 4 □Unknown
<u>a</u> œ	as be	Completed							24a. Was autop	sy prio	re autopsy findings available to completion of cause of
The The	certificate has t irector, page 2 s								1 Yes	2 □ No	Ŷes 2□ No
OT VICAL Physicien: T	is certific director,	o Be	25. Was case refer examiner?		Hospital:	nt 2 ER/Out	patient 3 DOA Ot	hor	ath (Check only o	ne) dence 6 ⊠Other (	(Specify) Scene
_	를 펼	<b> -</b>	27. Manner of Deat	h	28a. Date of hjur (Nonth Day	y 28b. T				now injury occurred	1 . 1
VISION r Attending	death. ctor: Aff y the fur	catio	1 Natural 2 Accident 3 Suicide	5 ☐ Pending investigatio	7/1/04	101	10 M 10	Yes 2 No	unver	ina	ooccident
Or Att	Direct in by	Certification:	4 Homicide	determined		iry - At home, far :. (Specify)	m, street, factory, office		City or Toy	vn, State)	or Rural Route Number,
Spitel	nerel rilled		29a. Certifier	1 Certifying Pf	hysicien: To the best of	of my knowledge	death occurred at the ti	ime, date and plac	e, and due to the	cause(s) and manne	er as stated.
he Ho	in 24 h	edicai	(Check only one)	2 XMedicel Exe	miner: On the basis of and manner sta	ted.	Vor investigation, in my				
Tot	within 24 hours after death.  To the Sunerel Director: A completely filled in by the fu	Σ	29b. Signature and	title of certifier	1			se number		29d. Date signed (A	
1	1		20 N	Lo	revul	)	OC Type Print)	ME		July 2,	2004
	1		30. Name and add	Ren (	completed cause of de	( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	111 P	enn Stre	et, Balt:	imore, Ma	ryland 21201
		ate.	31. Date filed (Mor		32 Registra	ar's Signature	hearth 1				
*	Regist	rar	g J	UL 0 8 20	104 Librer	J. J.	STORE OF THE PROPERTY OF				

			for State	State of Ma	ryland / Depa			<i>l</i> lental Hygi	ene				
	-		Registrar  1. Decedent's Name (First, Middle, Lasi	)	Ce	rtificate of	Deam	2. Date of Death	g. No.2 () ()	3. Time of Dealth			
	Physici			Martha Ani	nice Griff	ith		Month July	Day Yea 1 2004	r			
>	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of De				
			Genesis Eldercar				imore			Arundel			
	Funeral Director		5. Social Security Number 6. Se 217 34 5665	37	(In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, August	Year) 1,1908 Pe	lirthplace (State or Foreign Country) ennsylvania			
	and **		Usuat Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits			
	Maryi f aho	tor	Maryland Anne Ar	undel	Linthic	um				1 ☐ Yes 22 No			
	h the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?			
	23a c	raiD	203 Exeter Court	,		210	90		U.S.				
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is merked other than "natural", or items 23e or 28e-f ahow or other traumatic event, it is Medical Evantinal must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify: W				
5-0	72 h	etec	15. Decedent's Edi (Specify only highest grad	cation le completed)	(Give	dent's Usual Occup kind of work done	during most of work	ting 1	6b. Kind of Busines	ss/Industry			
21215-0036	od within giene.	Completed	Elementary/Secondary (0-12) 8th	College (1-4or 5-	.)	DO NOT use retired nemaker	d)		Own Home				
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "raumatic event, Ita Men	To Be	17. Father's Name (First, Middle, Last) William	M. Moyer				ah Frant:					
Mary	and 2 shouealth and N man 27 is me	-	19a. Informant's Name/Relationship (T)  Carolyn Moyer	vpe, Print)		ng Address (Street Exeter Co	and Number or Run urt Li		City or Town, State Maryland				
lore,	Pages 1 and 2 nent of Health int: If item 27 I iry or other tre		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I		20b. Place of Dispo cemetery, cred Odd Fello	natory or other place	ce)		Oc. Location - City	or Town, State			
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item any injury or othe once.		*4 □ Donation 5 □ Other (Specify, 21. Signature of Lineral Service Lineral	12.2	22	2. Name and Addre	ss of Facility GC	nce Fune	ral Servi	.ce, P.A.			
	40 E E B		23a. Part 1. Enter the disease, or complications that ceused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line	Consequence of):		ng, such as cardiac	or respiratory arres	St,	Approximate Interval Between Onset and Death			
	Examiner	_	Sequentially list conditions		ONE YEAR								
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	CH	consequence of): 2FSRO VA	CUI AR	XICEA	8E		DAVE YEAR			
ó	cate be executed physician and the burial-transit	Exal	that initiated events resulting in death) Last	•	consequence of):	-0-0///	212011			100 /01/17			
8760,	ate be hysici the bu	dical	C	d									
Box 6	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12, months? 1	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of d Month	elivery Day Year			
P.0	that the de led by the a detached	Phy	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	nderiving cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?			
Records,	w requires that been signed t should be det	ted by						1 🗆 Yes	A .	Probably 4 □Unknown			
-	The lay ate has page 2	Completed						24a. Was an autopsy perform 1 Yes 2	prior to death?	autopsy findings available ocompletion of cause of			
Vital	Physician: The this certificate rat director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		h (Check only one,					
of	Phys this rat did	. To	1 ☐ Yes 2 X No 27. Manner of D 4th	1 U Inpatien		it 3 DOA	4 Nursing Ho	ome 5 Residen 28d. Describe how	ce 6 Other (Sp	ecify)			
lon	Attending I r death. ector: After by the funer	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Yeer) Injury	Wor	k? Yes 2 □ No	254. 2555155 1151	injury cocurred				
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	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifying Phy (Check only one)  Certifying Phy 2 Medical Exam	sician: To the best of ner: On the basis of and manner stat	examination and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manner a e and place, and du	as stated. ue to the cause(s)			
	To the within To the compl	Me	29b. Signature and title of certifier	7 1 5		29c. Licens			d. Date signed (Mor	nth, Dey, Year)			
•	A.		· Could his	Town.	40	129	807		7/2/01				
	10		000 - 1	empleted cause of de	ath (Item 23a) (Type,	Print) (06/40	807 065.CR	YN AWY	GLEN	BURNIE 21061			
	Sta		31. Date filed (Month, Day, Year)	32. Registra	's Signature	1.							

			1 = For State Registrar	State of Mary		artment of F rtificate of I			jiene	11,	21349
			1. Decedent's Name (First, Middle, Last	)				2. Date of Dea	th	V	3. Time of Death
	Physici		Sokratis Gia	nnakoulias				June 26	Day 2004	Year	7:00 a M
}	/Medio Examir		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of Deat			y of Deeth	7:00 4
	ZAGIIII		828 S. Ponca Stree	s.t		Ralt:	imore			N/A	
	Funeral		Social Security Number 6. Se	x 7. Age (In	yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year		lece (State or Foreign
	Director		214-68-2555	<sup>M 2□ F</sup> 65	Yrs.	World's Days	FIOUIS WIII	Feb. 26	,1939	Gre	
	P >		Usuel Residence of Decedent  10a. State 10b. County	100	c. City, Town or L	postion				1	0d. Inside City Limits
	shov	_		100	•						1√2 Yes 2 No
	289-1	Director	Maryland N/A			Baltimore			0- 04	14/1	
	with or		10e. Street and Number 828 S. Ponca Stree	- t-		10f. Zip Code	21224	1	Og. Citizen of	what Cour	ntry ?
	hours after death with the Maryland tural', or Items 23a or 28e-f show al Examiner man be rediffed at	Funerai		12. Was Decedent Ever	in IIS 13	Was Decedent of H			U.S.A.	ce - Americ	an Indian
	Items (	Ě		Armed Forces?	11 0.3.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)		ck, White,	
39	irs af	by	1 ☐ Never Married 2 ☐ Married 2 ☐ Midowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Speci	<sup>∱</sup> whit	e
ğ	n 72 hours "natural", edical Exe	ed	15. Decedent's Edu	cation		dent's Usual Occup			16b. Kind of 8		
75	.5 - #	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of wo d)	rking			
21		E O	12		Mac	ninist			Westin	g Hou	se
B	be filed Ital Hygi od other event, II	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, i	Maiden Suma	me)	
<u> a</u>	should be id Mental marked c	20	Ronstadinos G	iannakoulias	5	6.0 in 10.0 in	Theod	ora Bikal	cis		
Maryland 21215-0036	d 2 should th and Men 7 is marks traumatic		19a. Informant's Name/Relationship (T)	rpe, Print)		ng Address (Street					
Σ	and 2 lealth m 27 her tra		Dianisia Giannako	ulias-wife	828	S. Ponca	Street B	altimore	, MAryl	and 2	1224
ore	- I 0 =		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐ F	,	Ob. Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	Date	20c. Location	- City or To	wn, Stete
Ĕ			`4 Donation 5 Other (Specify)		Oak Lawn	Cemetery	6/2	8/04	Baltin	ore.	Maryland
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens		2	2. Name and Addres	ss of Facility Ch	arles S.	Zeiler	- & Sc	n, Inc.
00	80 = 50		Jesseick 1	LOCK	6	224 Easte	rn Avenu	e Baltimo	ore. Ma	rvlan	d 21224
			23a. Part   Enter the disease, or complete shock, or heart failure. List only o	ications that caused the							Approximate Interval Between
	Physician	4 8	Immediate Cause (Final disease or condition	metast	oto 1	In sm	all cell	lune	CONC	w	Onset and Death
	/Medical		resulting in death)	Due to (or as a cor		2011 31.		100.5	CONIC		10110-4-0
	Examiner		Sequentially list conditions.	b							
	D #	Examine	Sequentially list conditions, say leading cause. Enter Underlying Cause (Disease or injury	Due to for as a cor	ns- uence of						
	and trans	cam		o							
90,	death certificate be executed e attending physician and of for use as the burial-transit			Due to (or as a cor	nsequence or):						
8760,	cate t	Physician/Medical		1							
9	death certifica attending ph d for use as the	Me	IF FEMALE:	270 16 400 040000 06 00					9		
Box	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1☐Live birth 2☐	Fetal death 3	Ectopic pregnancy	,			ite of delive onth	ry Day Year
<u>o</u> .	at the de by the a rached f	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify)					,
ď.	that the		Part II. Other significant conditions co.	ntributing to death but go	t reculting in the u	ndarkina onuca au	on in Part I	23a Did tol	2202 1150 005	tributa to th	e cause of death?
JS,	Se De	by	Tath, other signment conditions co.	minoding to coder but no	r 1938iting in the c	niderlying cause give	on ar arti.	1 D Y			ably 4 Dunknown
0	w requir been si should	etec									
ec	R 25 CA	Completed						24a. Was a autops	y	prior to con	psy findings available inpletion of cause of
=	Th ate pag	Cor						perform	No Neg?	death? 1 ☐ Yes	2□ No
of Vital Records,	Physician: This certificatal director, p	Be	25. Was case referred to medical examiner?	to a shall		1		ath (Check only on	e)		
£	S S	မ	1 Yes 2 No		2 ER/Outpatie		4   Nursing F	dome 5 Peside	nce 6 □Otl	ner (Specify	)
n c		on:	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	Worl		28d. Describe ho	w injury occur	red	
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No				
Division	r ffe	Certification;	4 Homicide determined	28e. Place of Injury - building, etc. (St	At home, farm, st pecify)	reet, factory, office		28f. Location (St. City or Town		ber or Rura	Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completaly filled in by										
	Hose Hose Fune Fune	edicai	(Check only 2 Medicat Exemi	sician: To the best of my ner: On the basis of exam	/ knowledge, deat mination and/or in	h occurred at the tim vestigation, in my of	ne, date and place pinion, death occu	e, and due to the ca urred at the time, da	tuse(s) and mate and place,	anner as sta and due to	ated. the cause(s)
	the thin 2 the mplei	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License	e number	20	9d. Date signe	d (Month (	Jay Vaari
\	T N N		235. Signature and title or certifiel		MI	200	4 / Palls (1995)	- COST			
	1		1 any	umain	110		31586	0	June	do	,2004
	y 1		30. Name and address of erson who co	empleted cause of death	(Item 23a) (Type.	Print)					
	1	- 1	No. AT	1110	200	2 11 /		CL O.	11.		11 17 17 1
7	Sta		No. AT	SON MD	22 Signature	Print) South GI	reene "	S+ Ba	Hmor	e v	10212 OM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** Arne Kristian Hansen 12:25 PM. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner GLEN ARUNDEL HOSPITAL BURNIE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Months Hours Days 1 X M 2 □ F 113-36-2380 76 Yrs. Director 18, Norway Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1106 Cedarcliff Drive 21060 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married ō 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) 10 Seaman Shipping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be finand Mental H Be "Unknown" Hansen "Unknown" 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1106 Cedarcliff Drive Thelma Hansen / Wife Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō <u>=</u> 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State July 8, 2004 ŏ Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Stevensville, MD Chesapeake Cremation <sup>22</sup> Name and Address of Facility Singleton Funeral Home PA l Second Ave S.W. Glen Burnie, MD 21061 61220 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit resulting in death) Last Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 No Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death
Natural
Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

to the Hospitet or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, death after death filled in by the completely within 2

Registrar

0

Medical

Date filed (Month, Day, JUL 08 2004

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

301 Hospital
32. Registrar's Signate

30. Name and address of person who completed cause of death (Item 23a) (T ype, Print).

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dav. Year)

Decoupled Name First Moths Asial Part of Country  Robert L. Haddeler  South South Works for destination, yet endeated methods.  Format Country				1- For Amend Item #3	Stater of Maryla	nd/Peg	artment rtificate	of H	ealth a	ind Me				. (	213	51
Robert E. Hadeler  Green Statement State Center  Formation  Format							rimouto	. 01 2	Journ				. 00 -	? (,	3 Time of	Death
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Physician / Medical Examiner    Physician   Physican   Physician   Physician   Physician   Physician   Physician	<b>10</b>	8989		1 ( Leh V )	Luz	R	uck To	WSO	1 Fune	eral	Home,	Inc.	lowso	n <sub>y</sub> Mo	1.2120	14
Physician Medical Examiner    Part	П			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cation that caused the de	eth. Do not en	ter the mode	of dying	, such as o	cardiac or	respiratory a	rrest,		11	nterval Betv	veen
Due to (or as a consequence of):		Physician		Immediate Cause (Final	1 14	2 hel	me's		di	1201	9			52	Onset and D	eath
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9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1   Yes   2   No   3   Probably   4   Unknown  24a. Was an additional provided completion of cause of graph of the course of graph of the course of death?  25. Was case referred to medical examiner?  25. Was case referred to medical examiner of the cause of death?  26. Place of Depth (Theck only one)  27. Manner of Julian of Julian of County of the cause of graph of the cause of graph of the cause of death?  28a. Did tobacco use contribute to the cause of death?  24a. Was an additional of the cause of death?  25. Was case referred to medical examiner of the cause of graph of the cause of graph of the cause of graph of the cause of graph of the cause of death?  25. Was case referred to medical examiner of the cause of graph of the cause of graph of the cause of graph of the cause of graph of the cause of graph of the cause of graph of the cause of death?  26. Place of Depth (Theck only one)  27. Manner of Julian of Julian of Graph of the cause of graph of t	20	ate b hysic the b			1									_		
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The state of the cause of death of the cause			Sici	1 ☐ Yes 2 ☐ No		ideath 5	Other (spec	cify)					WORTH		ay i	<del>o</del> ai
The state of the cause of death of the cause		at th	Phy			40					00 014					
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25. Was case referred to medical examiner?  1	Ö	law las b	ple								autor	osy	24b. Were	autops to comp	y findings a detion of ca	vailable use of
28. Place of Death-TCheck only one)  28. Place of Injury at Work?  1   Yes 2   No  28. Place of Injury at Work?  1   Yes 2   No  28. Location (Street and Number or Rural Route Number, City or Town, State)  29. City or Town, State)  29. Signature and Little of Sertifier  29. Signature and Little of Sertifier  29. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	<u>r</u>		Son								perfo	rmed?	deat	1?	_	
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Solution of the control of the contr	_	hysic his c	2	1 ☐ Yes 2 ☐ No	1 Unpatient 2				4 Thurs	sing Hom	e 5 ⊟ Resi	dence 6	3 □Other (S	Specify)		
The state of the s	_	ng P	on:		28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 280	c. Injury Work	at ?	28	d. Describe	how injur	y occurred			
29a. Certiflier (Check only on the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and Little of sertifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	<u> </u>	eath.	cati	2 Accident investigation		1		-	′es 2□N	10						
29a. Certiflier (Check only on the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and Little of sertifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	Ž	or Att	Ė	determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	eet, factory,	office		28				Rural F	Route Numb	ρθ <i>Γ</i> ,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. JOSEPH A ADAM) (7/1/W CHARLE) ST (UITE 4/07)		urs al								1						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. JOSEPH A ADAM) (7/1/W CHARLE) ST (UITE 4/07)		Hosp 4 hol Fune Fune	ical	(Check only 2 Medical Exami	ner: On the basis of exami	nowledge, deat nation and/or in	h occurred at vestigation, i	t the time n my op	e, date and inion, deett	i place, an h occurrec	d due to the at the time,	cause(s) date and	and manner place, and	as state	ed. ne cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. JOSEPH A ADAM) (7/1/W CHARLE) ST (UITE 4/07)		the	Med	one)	and manner stated.											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR JOSEPH A ADAM) (7/1/1 N/ CHARLE) ST (USF 4/07)		T W C	_				1	-	- ~	122		7	signed (M	C.	,, , oai/	
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			1 - For Registrar		of Maryland	/ Dep		t of H	ealth a	and N	Mental Hy		000	l,	2135	2
	Dhuaisi		Decedent's Name (First, Middle	e, Last)							2. Date of D. Month	eath Day	, Y	ar	3. Time of Deat	7**
	Physici /Medio		Charles		Ernest			Head	gie	Ir	July		2004		3:58p.	M
	Examir		4a. Facility Name (If not institution	n, give street and	number)		4b. City,	Town, or	Location	of Death		4c.	County of E	Death	_	
			Joseph Riche	v House	2		Bal	timo	ore							
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. Ia		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	irth lay, Year)		Birthpl. Count	ace (State or Fore	sign
	Director		212-60-9862	<b>X</b> XM 2□ F	50	Yrs.					06 3	0 5	54		1D	
	pud *		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	ocation							10	Od. Inside City Lin	nite
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	item item	un	11. Marital Status	Armed	ecedent Ever in U.S Forces?	. 13.	if Yes, spec	eify Cuba	spanic Ori n, Mexicar	n, Pu <i>e</i> rto	ecify Yes or N Rican, etc.)	0-	14. Race - / Black, V			
36	hours after death with the Maryland turel', or items 23a or 28e-f ehow al Examinar must be notified at	by F	1 X Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes,	s 2 □ No Give r Dates:		1 ☐ Yes	<b>X</b> No	Specify:				Specify:	Bla	ck	
21215-0036	be filed within 72 hours after death with the Marylar tal Hygiene. d other than "naturel", or items 23a or 28e-f show other than "naturel", or items 23a or 28e-f show went, the Maxical Examinar roust be notified at	ed		t's Education		16a, Dece	dent's Usua	al Occupa	ation		_	16h Kir	nd of Busin			
15	within 72 ene. than "nai	Completed	(Specify only highe	st grade complete		(Give	kind of wo	rk done d	turing mos	t of work	ing	102171				
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D	filed Hygi other ent,		17. Father's Name (First, Middle,				010.	. 100		er's Nam	e (First, Middle			T L !!		
Maryland		To Be	Charles E. He	agio					Cal	- hor	ine F	10	16.0			
2	d 2 should by th and Menta 7 is marked treumetic ev	-	19a. Informant's Name/Relations		17	19b. Maili	ng Address	(Street a			al Route Numb			te, Zip (	Code)	
S	d 2 7 is		Chamina Clamb				100								0101	
ā,	- ± 5 ≠		Charine Clark 20a. Method of Disposition		20b. Pla	ice of Dispo	osition (Nan	ne of	rde i	xoac	Bal Date	20c. Lo	cation - City	y or Tov	vn, State	
Baltimore,			XXBurial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (S	3 Removal fro	m State	metery, cre	•			_		2002		1000		
Ė	permit. Page Department i Importent: if eny injury or	21. Signature of Funeral Service Licensee 22. Name and Address of Facility												lls, M	đ	
Ba	Deport Impo		3 1,000	Edan			Marc	h F/	'H We	est	- 1		_	-	01015	
	_		23a. Part1. Enter the disease, or	complications that	at caused the death						Bal		re M		21215 Approximate	
			shock, or heart failure. List Immediate Cause (Final	only one cause of	n each line.	201101011		o or dynn	g, 30011 a3	cardiac	or respiratory t	arrost,			Interval Between Onset and Death	
	Priysician /Medical		disease or condition resulting in death)	a	AIDS										15 400	8
	Examiner			Due	to (or as a conseque	ence of):										
		<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due	to (or as a conseque	ance of):								-		
_	ed isit	ij	cause. Enter Underlying Cause (Disease or injury	< □	(0) as a conseque	51100 01).										
	and and I-trar	Examiner	that initiated events resulting in death) Last	c	to (or as a conseque	ence of):								-		
68760,	death certificate be executed e attending physician and of for use as the burial-transit	icai E			(											
87	physicate I	dic		d												
×	leath certific attending p	Physician/Med	IF FEMALE:	23c If yes	outcome of pregnan	cv				,			20 d D - 1			
Вох	atten atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Liv	e birth 2 Fetal or	death 3[	Ectopic pr					2	23d. Date of Month		y Day Year	
o.	at the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Un		1(I) 5(	Other (sp	өспу)								
<b>a</b>	The law requires that the ste has been signed by the bage 2 should be detached.	Ph	Part II. Other significant condition	ons contributing to	death but not result	ting in the u	nderlying c	ause dive	en in Part I		23e. Did	tobacco u	se contribu	te to the	e cause of death?	
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/ita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?					100		of Deat	h (Check only	one)		-		
of o	Physi this o	2	1 ☐ Yes 2 No			R/Outpatie			4 L NU	rsing Ho	ome 5□Res		Other (	Specify)	HOSPICE	
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Sio	Attending it death. ector: Atterby the fune	cati	2 Accident investi	not be			М		/es 2□	No						
Division	r ite	Certification:	4 Homicide determ	1208. Pla	ace of Injury - At ho <i>n</i> ilding, etc. <i>(Specify)</i>	ne, tarm, st	reet, factory	, office				(Street and wn, State)		r Rural	Route Number,	
	urs a		V													
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	To the Hospital of within 24 hours af To the Funeral completely filled in	Med	one)	and m	anner stated.			. License					e signed (M			
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			31. Date filed (Month, Day, Year)	DY, M.D	Pagistrada Simo	WUB!	KIUG	C A	UN,	100	14/1/11/6	KE,	MU.	1/0	2/2	
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358 PH

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2:30 pa **Physician** 200 4 Charles Melvin Harris Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Bultimore Good SomeriTE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral ™**M 2□F Yrs. Director 219-16-8383 21 80 MD Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County if Health and Mental Hygiene. itam 27 Iams 23a or 28a-f show itam 27 Ia marked other than "natural", or Itams 23a or 28a-f show other traumatic event, If a Modes. Exemplies at 1 Yes 2 □ No Directo NA Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21239 U.S.A. 1626 Winford Road Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Plumbing Social Security Adm 12th grade 2yrs+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Harris Sr. Mary Bell Rice ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice Harris-Wife 1626 Winford Road, Baltimore Md 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State <sup>1</sup> 4 □ Donation 5 □ Other (Specify) Garrison Forest Vet. 7/12/04 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Probable myo cardial **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Dinknown Completed 4b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No To the Hospital or Attanding Physician: Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 7 No 2 ER/Outpatient Certification: To 1 Tyes 1 Inpatient 3□ DOA After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending 2 No investigation 1 🗌 Yes 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier DOO42658 July 3, 2004 30. Name and address of person who complete ause of death (Item 23a) (Type, Print) Lock Roven Blud Baltimore 5601 6. zolew 32. Registrar's Signature State Registrar

		1	For state Registrar	State of Ma	ırylan	•	artmen rtificat			and M		Reg. No.	104	21351	
Physi	cian	Doric Harris									Year	3. Time of Dealis			
/Med	lical	6 21 2004									2004	7:15 p.			
Exam	iner	4	4a. Fecility Name (If not institution, give street and number) 4719 Maryknoll Road Pikesville							n Deetti	4c. County of Death Balto				
	Funeral Director 5. Social Security Number 214-14-7797 1						If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Mopth, D	rth 8-1914		Birthplace (State or Foreig Country) Md	
and *		-	Usual Residence of Decedent  Oa. State 10b. County		10c. Cit	y, Town or Lo	cation						1	Od. Inside City Limits	
Maryl. f sho	ō		Md Balt	-0		Pikesv								1 ☐ Yes ŽŽNo	
the 1	rect	1	0e. Street and Number			- I IKES	10f. Zip	Code				10g. Citizen	of What Cour	ntry?	
h with	0		4719 Maryknoll Roa	ıd				212	208			U	SA		
deat	ner	1		12. Was Decedent I Armed Forces?	ver in U.	.S. 13.	Was Deced	dent of H	ispanic Ori	gin? (Spe	ecify Yes or Ne Rican, etc.)		Race - Americ Black, White,		
DAILLINOTE, MIST YISTIC Z I Z I 3-0030  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, it a Mudical Examinar must be notified at	by Funeral Director		1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo		1 ☐ Yes		Specify:		riioari, etc.,			ack.	
72 hc	Completed		15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Dece	kind of wo	rk done d	durina mos	t of worki	ing		f Business/In		
Athin A	훁	·	Elementary/Secondary (0-12)	College (1-4or 5		life.	DO NOT U	se retired	)			Baltim		2	
A & lied villed			12th grade 7. Father's Name (First, Middle, Last)	3 year	S	N	urse		18 Mothe	r's Name	(First, Middle		c Scho	001	
arre	To Be	1	William Savoy								oeth Wi		raine)		
Maryiarro	1		19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailir	na Address	(Street a			il Route Numb		wn. State. Zid	Code)	
Mac S and 2 s			Theresa McNeil -				Mary				Pikesv:				
Daltimore, Marylatin Z.I.Z. permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, II a.M		2	0a. Method of Disposition	:	20b. P	Place of Dispo emetery, crei	sition (Nar	ne of	(a)		Date		on - City or To	own, State	
Page ento nt: If			1 XBurial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)			rbutus	•			5-28-	-2004	Arbut	us, Md		
SAITIMORE,  Demit. Pages 1 a Department of Hec mportant: If item any injury or othe	9	:	21. Signature v u ral Service Licens		<u> </u>		. Name an				arch F				
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ate be executed  ate be executed  Mysician and  hysician and  hysician in the burial-transit	ai .		23a. Part 1. Eriter iffe disease, or compleshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Exquentially list conditions, and, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events resulting in death) Last	ne cause on each lir	ne. NIC a conseq erter a conseq	renal uence of): 15100 uence of):			cien		or respiratory a	arrest,	25	Approximate Interval Between Onset and Death	
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Medical E		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 PMo 9 Unknown	d 23c. If yes, outcome 1	of pregna 2 □ Feta	ancy	Ectopic pr						Date of delive Month	ery Day Year	
quires that n signed that aid be det	ed by P	F	Part II. Other significant conditions co	ntributing to death b	ut not res	ulting in the u	nderlying c	ause give	en in Part I.			tobacco use c		ne cause of death? pably 4 Unknown	
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or A or A Direction	Certification:		3 Suicide 6 Could not be 4 Homicide determined	eet, factory, office  28f. Location (Street and Number or Rural Route Number City or Town, State)					al Route Number,						
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Regi	State strar		31. Date filed JULth, 038 2004	3. Registra	ar's Signa	ture	Spa	Kal						-	

			1 - For State Registrar	State of Ma		artment ertificate			-	giene Reg. N.R. (	) n i.	2125	£	
	© Dhuaia		1. Decedent's Name (First, Middle, Last)	HENDERS					2. Date of De Month	COST CO	Year	3. Time of De	ath	
	Physici /Medi		WILLIAM G.			JULY (			5:00 A	М				
ز	Examir	ner	4a. Facility Name (If not institution, give s			tion of Death		4c. Co	unty of Deat	th				
		*	36 CARROLL ROAD	7 4-0	(In constant late to		SADENA	nder 24 Hrs.				NDEL CO.		
	Funeral Director		5. Social Security Number 6. Sec. 15 232-62-5430	_	(In yrs. last birthday 67 Yrs.			urs Min.	8. Date of Bin (Month, Da Aug. 30	th 1 1036	9. Birl	thplace <i>(St</i> ate or Fi buntry) St Virgin	oreign	
			Usual Residence of Decedent			1			nug. 30	1750	Wes	or virgin	ша	
	nylan ihow	_	10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside City L	imits	
	Ba-f s	cto	Md. Anne Arur	ndel Co.	Pasade	ena						1 🗌 Yes 2	X No	
	th with the 23a or 23	ai Director	36 Carroll Road			10f. Zip C		122			of What Co	ountry?		
980	be filed within 72 hours after death with the Maryland hat Hygiene. ad other than "natural", or Itams 23a or 28a-f show avant, it a Medical Examiner must be notified at	by Funerai	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced		Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☒ No Specify:				14. Race · American Indian, Black, White, etc. Specify: white					
Õ	72 ho	ted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work							16b. Kind of Business/Industry				
21	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	life	DO NOT use	aone auring retired)	most of worki	ng	11 D	0			
2	ygien ygien yer th	Co	12	+4	Ch	emist					Grace	2		
Baltimore, Maryland 21215-0036	should be fill of Mental H markad ott matic avan	To Be	17. Father's Name (First, Middle, Last) William O.	Hender	son				(First, Middle, e11e	-	mame) ttle			
, Mar	od 2 s lith ar 27 is r trau		19a. Informant's Name/Relationship (Ty) Margaret J. Hender	, ,					dena, M			Tip Code)		
ore	of He of He fitarr		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ R	amount from State	20b. Place of Disp cemetery, cre	osition (Name amatory or othe	of er place)	i D	ate	20c. Locati	on - City or	Town, State		
Ĕ	Pa ant ury		'4 □Donation 5 □Other (Specify)	)	Highlawn	Cemet	ery	07/09	/2004	Oakhi	11, W.	. Va.		
Ball	permit. Pages 1 au Department of Hea Important: If itam any injury or othe once.		21. Signature of Funeral Service Licens	Som	mll)	22. Name and MCC 1	Address of F ully F 4 Moun	olynia otain R	k Funer oad, Pa	al Ho saden	me P.A a. Md.	A. 21122		
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only of	ations that caused the cause on each line	he death. Do not er							Approximate Interval Betwee	en.	
Ų	Physician	1	mmediate Cause (Final disease or condition	meto	-1			Canc				Onset and Deal		
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687	ficate physics the	edicai	d											
Вох	eath certific attending p	M/U	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of						23d.	Date of deli	verv		
о. В	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 5 Other (specify) 9 Unknown								Day Year			
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5 S	w requires been signe should be	pe pe							1 🗆 Y	es 2 🗆 N	3 🗆 Pro	obabiy 4 <b>X</b> Unkn	iown	
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	Physic this ce al dire	To E	1 ☐ Yes 2 XNo	ospital: 1   Inpatient	2 ER/Outpatie	nt 3 DOA	Other: 4	Nursing Hon	ne 5 KResid	ence 6 🗆	Other (Spec	ify)		
ט	Attending Physician: r death. ector: After this certific: by the funeral director.		27. Manner of Death  1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day )	/ear) 28b. Time of Injury	of 28c.	Injury at Work?	2	8d. Describe h	ow injury oc	curred			
sio	ttendi death. stor: A	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 ☐ Yes 2							
Division of		Certification:	4 Homicide determined	28e. Place of Injury building, etc.	· At home, farm, st (Specify)	reet, factory, or	ffice	2	8f. Location (S City or Town	treet and Nu n, State)	ımber or Rui	al Route Number,		
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	To the Hospital or within 24 hours afte To tha Funaral Dir completely filled in I	Medicai	(Check only 2 Medical Examin	er: On the basis of eand manner state	xamination and/or ir	ivestigation, in	my opinion.	death occurre	d at the time, d	ause(s) and late and plac	manner as : e, and due !	to the cause(s)		
	To the Hospita within 24 hours To tha Funaral completely filled	Me	29b. Signature and title of certifier			29c. L	cense numb	190	2	9d. Date sig	ned (Month,	Day, Year)		
	14		) mu	M.D.			D54	413		07-	-06-	2014		
	1041	1	30. Name and address of person who cor		th (Item 23a) (Type,	Print)	-		0.					
	1		Young J. L	ee 30	015.40	moves	2 5t.	Ba	timor	e m	D 2	1225		
	Sta Registr	-	31. Date filed (MontH, Day, Year)  JUL 0 8 2004	32. Registrar	s Signature	book	/					Day, Year) 2004		

			1 - For State Registrar	State of	Marylan		artment rtificate				lental Hy	giene Reg. Ne	200		2135	6
			1. Decedent's Name (First, Middle, Las	it)							2. Date of De Month	ath Day	·	Yeer	3. Time of Deat	h
	Physici /Medic		Katherine Franci	s Harr							07	06		004	4:50 P	М
al.	Examin		4a. Fecility Name (If not institution, give	street and num	nber)		4b. City, T	Town, or	Location of	of Death		4c.	County	f Deeth		
			Genesis Elder Car				If the dead		Caton				В		more	
	Funeral		5. Social Security Number 6. S	ex □M 2□XTF	7. Age (In yrs. O t		If Under Months	Days	If Under Hours	Min.	8. Date of Bird (Month, Da	y, Year)	110	Coun		aign
	Director		212-22-3834 Usuel Residence of Decedent		85	)					Nov. 5	, 19	18	Oh	10	
	yland now		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside City Lin	
	Mar-fish	tor	MD N/	A			В	alti	imore						1X Yes 2□	No
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of W	hat Coun	itry?	
	23a	la	3402 Brendan Aven						1213				ted			
	ar de	Funeral	11. Marital Status	12. Was Dece Armed For	ces?	.S. 13.	Was Decede If Yes, speci	ent of Hi ify Cuba	spanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	-		· Amend , White,	an Indian, etc.	
36	rs aff	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Give Year or Da	θ -		1 ☐ Yes 2	No 🎑	Specify:				Specify:	Whi	te	
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e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itema 23a or 28a-f show ampiritury or other traumatic svant, the Medical Examinar must be indiffied at ance.		Deborah Dackman  20a. Method of Disposition	Daught							c., OWl		MILL ocation - 0		D 21117 wn, State	
<u>o</u>	Pages nent of ant: If its ary or o		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		State Me	Place of Disponentery, created adown 1 and	dge Dark	ner piac	<i>θ)</i>	7_0.	-2004	FIL	ride	o M	D	
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N C	After tunera	lon:	27. Manner of Death  1 Anatural 5 Pending		of Injury h, Day Year)	28b. Time o Injury	f 28	Bc. Injury Work	rat ∢? Yes 2. □		28d. Describe I	how inju	ry occurre	d		
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	To the To the Comp	Me	29b. Signature and title of condier				29c.	License	number			29d. Dai	te signed	(Month, I	Day, Year)	
			Leeman Layor	MD				127	541			JU	ly	7,	X004	
	0		29b. Signature and title of control  A LL Mar Leyer  30. Name and address of person who  GETHA RHJ	completed caus	e of death (Iter	m 23a) (Type,	Print)		D.I	Dr. 1	tibacas.	o i	MA	- 01	227	
	4		GEETHA KNJA	J-141), 4	1001	7101111	IS It	004	14)	rekil	71116110	'/		I	44/	
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DHMH 17 Rev 1/2001

ORIGINIAL

unpend item#23a-b,27,PER ME,G833,7/27/04eg Tracie Harding Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-04438 State of Maryland / Department of Health and Mental Hygiene RPD Registrar AMEND ITEM #5 PER FH C835 9 POSSIFICATE DE ATH 1. Decedent's Name (First, Middle | ast) 2. Date of Death **Physician** Year 7, Tracie Dawn Harding /Medical July 2004 0130 AM 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore 8. Date of Birth (Month, Day, Year) Jun. 8, 19 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 216-06-4819 Birthplace (State or Foreign Country) Days Months Hours 1 ☐ M 2 🛛 F Min Director 34 Yrs 1970 Maryland Usual Residence of Decedent Maryland 10a State 10h County 10c. City, Town or Location item 27 Is marked other than "naturel", or Items 23s or 28e-f show other treumatic event, tre Mudical Experiment must be notified at 10d. Inside City Limits Director MD N/A 1 XYes 2 No Baltimore the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WITH 3023 Mardel Avenue death v Funeral 21230 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Banquet Manager Country Club permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If item 27 Is marked othe eny injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Robert Harding Patricia Mary Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Harding Father 8051 Wolsey Court, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State □ Donation 5 □ Other (Specify) Loudon Park Cemetery 7-10-2004 Baltimore, MD 21. Signature of Funeral S 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of): **Examiner** Pneumococcal Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the as esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has page 2 1 Yes 2 No 1 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No 2 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28c. Injury at Work? After Certification: 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending death. investigation after death Director: / 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature e of 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 7, 2004 30. Name and address of person who complete can e of death (Item 23a) (Type, Print) HOGAV 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 8 2004 Registrar

/Media	an	1. Decedent's Name (Filst, Middle, Las	ent's Name (First, Middle, Last)  LAWRENCE JARVIS  2. Date of Death Month							UN, 25,2004 3. Time of Death		
	al	4a. Facility Name (If not institution, give	street and number)			tv. Town. or	Location of Dea	th	4c. Cc	ounty of Dea		
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and the	by F	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1X Myes 2 ☐ If Yes, Give Year or Dates:	No	1 ☐ Yes	2[ <b>X</b> No	Specify:		Sp	ecify:	Black	
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	-	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	NUNC	4c. County of Death	
				NOSEDH RICHIE HOUSE BALTO.		NA.	
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yes	9. Birth	nplace (State or Foreign untry)
		Director		Usual Residence of Decedent	JONE 24,	1970	MD.
		yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
		e Mar sa-f sl	ctor	MD. NA BALTIMOKE			1 Yes 2 □ No
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		r Herr	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes   Yes, specify Cuban, Mexican, Puerto	ecry Yes or No- Rican, etc.)	14. Race - Amer Black, White	
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	Maryland 21215-0036	2 should and Men Is marker aumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura	al Route Number, Cit	y or lown, State, Zi	
		permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Marical Exercities out the traiting an once.		GERTRUDE CHERRY 724 E. 25/4 ST. E	ACTIM	ORE, MI	1. 2/2/8
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15	- <u>E</u>	it. Pa intmer intant: njury		'4 Donation' 5 Other (Specify) BAVI Ew (REM; 20	204 75	ANTO.	NO
M	Ba	permit. Departr Imports any inj		21. Significance of Notified Service Licensee	2529 4	WISEN	37
1				23a. Part1. Enter the disease, or complications that caused the death, bo not enter the mode of dying, such as cardiac or	or respiratory arrest,	140.	Approximate
		Physician		Immediate Cause (Final			Interval Between Onset and Death
		/Medical		disease or condition resulting in death)  a			5 years
m ( h2 )		Examiner	_	Sequentially list conditions, b			
75	X	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying			
9	1	executed n and ial-transit	xan	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
-1	8760,	be	dlcal	d			
le	9	certificate iding physise as the	Medi				
Ž.	30X	ath cer tendir or use	an/h	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of deliv	•
1	O.	the death y the atter ached for u	Physician/Me	1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 □ Other (specify)		Month	Day Year
A	Э.	uires that the death certific signed by the attending p d be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to t	he cause of death?
	rds	es bed	d by				bably 4 Dunknown
3	Vital Records	law requir as been si 2 should	Completed		24a. Was an	24b. Were auto	opsy findings available
W-5>	Re	sician: The law certificate has t irector, page 2 s	omi		autopsy performed?	prior to co	ompletion of cause of 2□ No
7	ital	sian: srtifica ctor. p	BeC	25. Was case referred to medical examiner? 26. Place of Death	1 □ Yes 2 ☑ 1 Check onlone	40   1   1   1   1   1   1   1   1   1	2   140
H	of V	Physician: this certific ral director.	ပ္	1 ☐ Yes 2 XNo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hor			V) Hospier
1)		ding Phys T. After this funeral di	lon	1 Senatural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how in	jury occurred	
S	Division	Attending r death. ector: After y the fune	flcat	a Could be the	28f. Location (Street	and Number or Run	al Route Number
SIRNE	5	al or / s after il Dire	Certification:	Suicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, Sta	ite)	i riodio ridinosi,
A		To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier  (Check only dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.)	and due to the cause	(s) and manner as s	stated.
1		thin 24th F	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number			
	<b>b</b>	₹ ¥ ₹ 8				Date signed (Month,	vay, teat)
		3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	6/	25/04	
	<u></u>				Mo 2120	4	
		Sta	7.7	31. Date filed (Month, Day, Year)  32. Registrar's Signature  STL 08 2004  South  South		/	
		Registr	ar	JUL 08 2004 Serve & South			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JULY Day RAYMOND JASION ARTHUR 3 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours **X** 2 F 217-30-5080 68 Director 01-18-1936 MARYLAND Usual Residence of Decedent with the Marylend 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other treumatic event, the Mcdical Examiner must be notified at Director MD. BALTIMORE LUTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1819 BLAKEFIELD CIRCLE 21093 S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Yes 2 No Hares, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 960-1 ☐ Yes 2 ◯XNo þ Specify: WHITE 3 ☐ Widowed X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) HEALTH CARE PLASTIC SURGEON PLUS YRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f Be EDWARD JASION IRENE LOKSTEIN ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a importent: if item 27 is any injury or other tree ARTHUR W. JASION (SON) 609 WOOD GLEN COURT, LUTHERVILLE, MD. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial ★ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) HILLTOP SERVICE CORP. 07-06-2004, TOWSON, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD.21204 23a. Part1. Enter the disease, of shock, or heart failure. Lis

Physician /Medical Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No

tmmediate Cause (Final disease or condition

resulting in death)

complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory only one cause on each line.	arrest, Approximate Interval Between Onset and Death
a Aspiration pheumonis	72 hours
Due to (or as a coissequence of):	72 hours
Due to (or as a consequence of):	
c. Sepsi3	72 hours
Due to (or as a consequence of):	1310
CVA	17
23c. If yes, outcome of pregnancy	23d. Date of delivery

Examine attending physician and for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Physician/Medical the Completed by

certificate

After th

Director

24 hours

To the within 2 To the

2

npletely

death.

Be

<sup>2</sup>

Certification:

Medical

P.O. Box 68760.

Division of Vital Records,

1 Live birth 2 Fetal death 4 Pregnant at time of death 9☐ Unknown

3 Ectopic pregnancy 5 Other (specify)

Month Day

> autopsy perform

2 2 No

9 Unknown

IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

2 🗆 No

Year

4:20 PM

1 Yes 2 XX

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown

25. Was case referred to medical 1 Yes 2 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only onel

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

241

St. Stutt# 203 6565 Charles 32. Registrat's Signature

Registrar

			State of Maryland / Department of Health and Me 1 - State AMEND ITEM 19A PER FR, G833, 07/08/04/04 Registrar	ental Hyg	giene	21
				2. Date of Dea		3. Time of Douth
	Physici /Medi		MARVIN HENRY JONES	July	3 20	2000 p M
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County	1
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1 If Under 24 Hrs.	8 Date of Birth	,	9. Birthplace (State or Foreign
	<ul><li>Funeral Director</li></ul>		219-52.3664 18M 20F 54 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day	Year) 1949	Birthplace (State or Foreign Country)     M
	pu .		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			
	Manyle f sho	ō	ND NA BALTIMORE			10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	ith the Marylar or 28a-f show	Director	10e. Street and Number 10f. Zip Code	1	log. Citizen of W	/hat Country?
	death with the Maryland ma 23a or 28a-1 show		436 S. AUGUSTA AVENUE 21229		L	ISA
	er dea Items	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Ves, specify Cuban, Mexican, Puerto R	cify Yes or No- lican, etc.)		e - American Indian, k, White, etc.
	036 urs aft	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:		Specify	BLACK
1	5-0 72 bo	eted	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of workin	a	16b. Kind of Bu	siness/Industry
	121 within than *	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12 TH GRADE  (Give kind of work done during most of working life. DO NOT use retired)  SUPERVISOR	,	TOANS	SPORTATION
	ifiled Hygid other	Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle,		
	/lan	To B	HENRY JONES LILLIE	JOHNS	SON	
	Maryland 21215-0036 at 2 should be filed within 72 hours aft the and Mental Hygiene. 27 is marked othar than "natural", or traumatic event, tra Marie Exert		19a. Informant's Name/Relationship (Tipoe, Print)  19b. Mailing Address (Street and Number or Rural  19b. Mailing Address (Street and Number or Rural			
	re, land Healt tam 2		436 S. AUGUSTA AVE  20a. Method of Disposition  20b. Place of Disposition (Name of Dispositio	7	TO . MD 20c. Location -	City or Town, State
	Pages nent of nt: If i		1 Surial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Cemetery, crematory or other place)  LOUDON PARK	1-04 F	BALTO.	No
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-1 show any injury or other traumatic event, it a Madical Exemination and entitled at once.		21. Signal re of Funerin Service Licensee 2 22. Name and Address of Facility VAUGHN C. GREENE F 5151 BALTO. NAT. PIK		SERVI	Œ
	1.0		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arr	est,	Approximate
	Prysician		Immediate Cause (Final disease or condition Atheros (Large # Cartho) (asc	Praha	Scene	Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	, , , , , ,	13 -07	VC du 3
		le.	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)			
	xecuted and I-transit	Examiner	that initiated events C.			
	. Box 68760, death certificate be executed e attending physicien and id for use as the buriat-transit		resulting in death) Last Due to (or as a consequence of):			
	687 ifficate g phys	edicai	d			
	Box 61 leath certific attending p	M/W	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy			a of delivery
5	O. B ne deal the att	Physician/Me	in the past 12 months?  1		Mor	ith Day Year
3	ds, P.O. irres that the de signed by the d be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contri	ibute to the cause of death?
3.	cords, w requires been signs should be	ed by	Hypercholesterolemia	1 □ Y	as 2□No	3 ☐ Probably 4 Unknown
101	O ≥ □ 20	Completed	<i>5</i> (	24a. Was a	n 24b. V	Vere autopsy findings available rior to completion of cause of eath?
3:	on of Vital Rec.	Con		perfore	med? d 2 No 1	eath? □ Yes 200 No
3	of Vital Physician: 1 Physician: 1 rithis certifical ral director, p	o Be	25. Was case referred to medical examiner?  126. Place of Death of			
12.	g Phys er this	-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28c.		ow injury occurre	
١).	ision ( ttanding F death. ctor: After / the funera	atio	2 Accident investigation M 1 Yes 2 No			
pt:	Division  or Attanding after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (St City or Town	treet and Numbe n, State)	or or Rural Route Number,
(	Division To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	nd due to the ca	ause(s) and mar ate and place, a	nner as stated. nd due to the cause(s)
	To the vithin To the comple	Me	29b. Signature and title of certifier 29c. License number	2	9d. Date signed	(Month, Day, Year)
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		July	3,2004
			Suran Esposito 400 Caton Avenue	Bull	timore	Morgland
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			<del></del>
	Registr		JUL 0 8 2004 Serve & Sparker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ENNIE 200 /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** 4c. County of Deeth Square HOS ROSE COLC.
If Under 1 Year | If Under 24 Hrs. anklin Di ta more 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, TUNE) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ▼ F Months Days Min Year 213-88-151 Hours Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, it is Marical Era interminate to confine an once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No To Be Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? CELTON U.S. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TORI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) TECRGE DNN 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow TEELIEN 1226 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 6 1 Burial 2 Cremation 3 F
1 Donation 5 Other (Specify) 3 □Removal from State gnature / Funeral Servic / icensee 82 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5ep 51 Physician 4 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physiclan/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 ☐ Probably 4 ★Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 2 No Division of Vital 1 Yes or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 ☐ Yes 2 🔀 📢 o 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2500000 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Drive 31. Date filed (Mooth 32. Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistrar Certificate of Death Rag. No. . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Joseph Mark Knott /Medical July 5, 6:50 A 2004 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4 Smeton Place Apt. C Towson <u>Baltimore</u> 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 XM 2 ☐ F Months Hours 219-05-5947 Yrs. Director 85 September 18, 1918 Maryland Usual Residence of Decedent the Maryland 10a. State show 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or Items 23a or 28a-f shov traumatic event, I've Modical Experiment has be notified at Director Maryland Baltimore 1 Yes & No Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 4 Smeton Place Apt. C 21204 Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Nøver Married 2 ☑ Married Baltimore, Maryland 21215-0036 ڄ 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be flied withir Department of Health and Mental Hygiene. Importent: If item 27 is marked other then eny injury or other traumatine and injury or other and in Elementary/Secondary (0-12) College (1-4or 5+) 5+ <u>Industrial Realtor</u> Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry A. Knott Martha M. Doyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kathryn W. Knott (Spouse) 4 Smeton Place Apt. C Towson, Maryland 21204
te 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ♥ Burial 2 Cremation 3 Removal from State 5 Other (Specify) 4 Donation Dulaney Valley Memorial Gohs. 7/9/2004 Timonium Maryland 21. Signature of Fundal Service Kilents 22. Name and Address of Facility 21204 uchou Ruck Tauson Funeral Home, Inc. 1050 York Road Tawson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Rars /Medical Due to (or as a donsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) as the burial-transit Due to (or as a consequence of): attending physician Box 68760 The law requires that the death certificate be Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 ☐ Other (specify) Records, P.O. the detached 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 99 ndrome with Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 No of Vital 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred To the Hospitel or Attending Division 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation М 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [ 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2200 (M) 20 who completed cause of death (Item 23a) (Type, Print) Name and address of person Charles St. Balto. Md 2120% Sinc 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

		1	For State Registrar	tate of Maryland / Depa Cea	artment of Health and I rtificate of Death	Mental Hygien	2001.	21364
	Physicia	an	1. Decedent's Name (First, Middle, Last)		Kina	2. Date of Death	ay Year	3. Time of Death 6: 20 AM
	/Medic Examin ———— Funeral	er	14a. Facility Name (If not institution, give street)  The Johns Harking  5. Social Security Number  6. Sex	7. Also (in yrs. last birthday)	4b. City, Town, or Location of Death  An I have leed if Under 24 Hrs.  Months Days Hours Min.	13	c. County of Death  n/a	lace (State or Foreign
	Director	٦.	213-52-8288	2 F 55 Yrs.			949 Mar	yland  Od. Inside City Limits  1 □ Yes 2 ☑ No
	with the M 3a or 28e-f	Funeral Director	10e. Street and Number 3870 Salem Church I		10f. Zip Code 21084		Citizen of What Coun United St	
936	be tiled within 72 hours after death with the Maryland ital Hygiene. ad other then "natural", or items 23a or 28e-f show event, the Madical Examiner must be notified at		TI, Wanta Status	Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Whi	etc.
Baltimore, Maryland 21215-0036	e filed within 72 hou al Hygiene. other then "natura vent, the Marical	Completed by	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+) (Give life.	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) Lesman	rking	Kind of Business/Inc	
land 2	ed at b	To Be C	17. Father's Name (First, Middle, Last) William King		Tina S	me (First, Middle, Maide alustio		
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timore	t. Partment		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem  '4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	oval from State cemetery, cre Dulaney	Valley Mem. Gdns	7/9/04 Ti	monium, M	Id.
Bal	Deparition Department of the policy of the p		23a Part 1 Enter the disease, or complicat	ions that caused the death. Do not en	2. Name and Address of Facility Schimunek Funeral 510 W. MacPhail Reter the mode of dying, such as cardia	oad, Bel Ai		O 1 4  Approximate Interval Between
8760, 4	The law requires that the death certificate be executed and be executed as the attending physician and an original and a page 2 should be detached for use as the burial-transit and a page 2.	dical Examiner	shock, or heart failure. List only one of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Ω			Onset and Death  Co YCCIS
.O. Box 6	at the death certific by the attending p trached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
<u>α</u>	w requires that been signed by should be deta	þ	Part II. Other significant conditions contri	buting to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacc 1 ☐ Yes	o use contribute to the	
of Vital Records,	i: The law ricate has be	Completed				24a. Was an autopsy performed 1	prior to cor death?	psy findings available mpletion of cause of No
V.	Physicien: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner?	pital: 1X Inpatient 2 ☐ ER/Outpatie	Other	ath (Check only one)  Home 5 Residence	6 ☐Other (Specifi	(y)
ion of	ing and		1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work?  M 1 \( \t \t \) Yes 2 \( \t \) No	28d. Describe how in	njury occurred	
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Street City or Town, Str	ate)	
	n 24 hou n 24 hou ne Fune	Medical	29a. Certifier (Check only one)  Certifying Physic 2 Medicel Exemine	<ul> <li>ian: To the best of my knowledge, dear: On the basis of examination and/or in and manner stated.</li> </ul>	th occurred at the time, date and place overstigation, in my opinion, death occurred.	e, and due to the cause urred at the time, date a	i(s) and manner as si and place, and due to	tated.  the cause(s)
	To th To th comp	Ň	29b. Signature and title of certifier	be and	29c. License number		Date signed (Month,	. /
	(v	ate	Laura Herpel 31. Date filed (Month, Day, Year)	pleted cause of death (Item 23a) (Type  Sohn S Hopkuns / for  32. Registrar's Signature	D0060970 spita (600 N.Wot	fe St. Ba	Hinore M	10 21287
	Regist		JUL 0 8 2004	Syrene B	pools			

DHMH 17 Rev 1/2001

Philip James Kessens Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-04163 Unpend Item #253427 Maryland (1893arth) 9104 Haalth and Mental Hygiene For State Registrar M.E.S Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** 12:00 PM June 25 2004 Philip James Kessens /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City

9. Birthplace (State or Foreign Country)

50 Indiana Baltimore
If Under 1 Year | If Under 24 Hrs. 3644 Dudley Avenue 8. Date of Birth (Month, Day, Year) July 2, 19 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 1X M 2□ F **Funeral** Months Days Hours 303-58-1198 53 Director Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits 10a State r than "neturel", or Items 23s or 28a-f show the Madical Extractional be notified at 1X Yes 2 □ No Funeral Director Baltimore Maryland N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3644 Dudley Avenue 21213 u. s. A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Amed Forces: 1 MYes 2 No If Yes, Give 1979 to Year or Dates: 1982 filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) 4 Years Flementary/Secondary (0-12) Medical Research Research Assistant other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt.
Department of Health and Mental Hy.
Important: If item 27 is marked other
any injury or other traumetic event. 17. Father's Name (First, Middle, Last) Ann Weber Robert Kessens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3409 Delray Dr., Fort Wayne, Indiana 46815 Jerry Kessens (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 🛣 Removal from State Fort Wayne, Indiana 1 4 ☐ Donation 5 ☐ Other (Specify) Catholic Cemetery 7/10/2004 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 3331 Brehms Lane, Baltimore, Maryland 21213 M. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shy Immediate Cause (Final disease or condition resulting in death) Hypertensive atherosclerotic cardiovascular disease Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for se a consequence off Examine burial-transit and Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 death certificate be Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year detached for 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, λq 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 ☐ Yes 2X No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) At Sounce Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Xes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: I or Attending Patter death. After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME June 29, 2004 Greenser HD Iasha who completed cause of death (Ite 23a) (Type, Print) Green berg H D 111 Penn Street, Baltimore, Maryland 21201 Tasha Z 82. Begistrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 8 2004 Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. Ne. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Deloves 08:39 AM ていし 6 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital 5. Social Security Number 7. Age (In yrs. last birthday) State or Foreign **Funeral** Months 1 □ M 2 🗹 F Yrs. Director 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits or 28a-f show ast be netified at 1 Yes 2 No To Be Completed by Funeral Director 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neture!" --- eny injury or other traumatic event. 14. Race - American Indian. cedent Fiver in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cliban, Mexican, Puerto Rican, etc.) orces? Black, White, etc. 1 ☐ Yes 2 IV If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify BIACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or Father's Name (First, Middle, Last) Mothe's Name (First, Middle, Maiden Suma 19b. Mailing Address (Street and Number or Rural Route Ob. Place of Disposition 20a. Method of Disposition Burial 2 ☐ Cremation 3 Removal from State \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit DIASSE nding physician and Due to (or as a consequence of) Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I the signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 99 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 1 ☐ Yes Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Tyes Certification: To 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural investigation 2 Accident within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year)

JUL 0 8 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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F.	REDDIE	LEV	VIS For State Registrar	State	or iviai	•	partmer e <i>rtificat</i>		lealth and I	Mental H				
			Registrar  1. Decedent's Name (First, Midd	le, Last)			crimeat	.001	Dealii	2. Date of D	Reg. N	200	Carlo	3. Time of Depath
	Physicia		Freddie					Lew	is	JULY	5, <sup>D</sup>	<sup>ay</sup> 2004	/ear	0230 A M
>	/Medic Examin		4a. Facility Name (If not institution		mber)		4b. City,	Town, c	or Location of Deat	h	4	c. County of	Death	
×		ō.	4839 CLAYBUR						ORE CITY					
	Funeral Director		5. Social Security Number	6. Sex 1 M 2 ☐ F		(In yrs. last birthda 52 Yrs.	Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	(Month, L	ay, Yea	r)	Counti	
			212-60-3682 Usual Residence of Decedent			J 2				08 2	29	51		/A
	irylan ihow	_	10a. State 10b. County	1		10c. City, Town or	Location						10	d. Inside City Limits
	Ba-f s	ecto	MD	NA		Baltim					10.0			1 X Yes 2 No
	with t	Funeral Director	10e. Street and Number				107. ZIP	Code	206		10g. C	itizen of Wh		ry ?
	ns 23	era	4839 Claybur	12. Was Dec	edent Ev	rer in U.S. 1	3. Was Dece	212	206 Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or N	lo-	14. Race -	America	
9	after or Ite	Für	1 Never Married 2 Ma	ried 1 Yes If Yes, Gi	2 X No		If Yes, spe			to Rican, etc.)		-,-	White, e	
215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "neturel", or Items 23s or 28s-f show ent, the Medical Exactinet must be notified at	d by	3 Widowed 4 Divorce	Year or D	Dates:							Specify:	Bla	
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<u>Jar</u>	Menta	To E	Richard Lewi	s					Betty (	Comer				
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	t and tealth em 2		Mary Lewis-S	ister		20b. Place of Dis		_	ry Aver	Date Ba		LINOTE Location - Ci		
nor	Pages nent of I int: If it		1 Burial 2 Cremation 4 Donation 5 Other (	3 Removal from	State	cemetery, c	rematory or o	other pla	ce) Park 7/1					wn, Md
Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Sign and or Fineral Service						ss of Facility.	.0,01	1,4.			
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ō	Attending Physician: r death. sctor: After this certification of the funeral director.	n: To	XXYes 2 ☐ No 27. Manner of Death	28a. Date	of Injury	28b. Time		28c. Injui Woi	4 C Indianid i	28d. Describe				AT SCENE
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	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical		Examiner: On the b		xamination and/or								
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	1)		30. Name and address of person	who completed cau		th (Item 23a) (Typ		1	D-74.	3.5		7.0-		
	Ch	**	CAPSILICA 31, Date filed (Mohin, Day, Year		Registrar	III P€	on Str	eet,	, Baltimo	re, Mar	y⊥ar	na 212	01	
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31. Date filed (JUL), DO, 8022004

32. Rec Registrar

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		*	Harbor Hospital Center Baltimore  5. Secial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. 0	Baltim	
	Funeral Director		219-30-3510 219-36-2153 1 M 20 8 80 Yrs. Months Days Hours Min. (1)	Date of Birth Month, Day, Year)  9. Bi 9. Bi 9. Bi 9. Bi	rthplace (State or Foreign SKRAINE
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Mary Feb	tor	Md. Anne Arundel Co. Baltimore		1 ☐ Yes 2 🏋 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23e or 28e-f ehow or other freumetic event, the Medical Exant as finultize in difficulation.	Funeral Director	10e. Street and Number 10f. Zip Code 21225	10g. Citizen of What C	-
	deat	ner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar	Yes or No- 14. Race - Am	
215-0036	ours after rel', or ite	by	1 Never Married 2 Married 1 Yes 2 MNo	n, etc.) Black, Wh	
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d 21	filed v Hygie ther t	e Co	4 0 Homemaker  17. Father's Name (First, Middle, Last) 18. Mother's Name (First)	Own Ho	me
Maryland	should be filed withir nd Mental Hygiene. marked other then metic event, the Mental the Mental control of the	To Be	Michael Sadowsky Anastasia	Lyba	
	and 2 sho salth and n 27 is m er treum		19a. Informant's Name/Relationship (Type, Print) Anton Lukianczuk (Husband) 19b. Mailing Address (Street and Number or Rural Roll 5504 Ballman Ave., Balt	ite Number, City or Town, State, imore, Md. 2122	Zip Code) 5
Baltimore,	ages 1 and of He ant of He y or oth		20a. Method of Disposition  1 \( \mathbb{M}\) Burial 2 \( \mathbb{C}\) Cremation 3 \( \mathbb{R}\) Removal from State  4 \( \mathbb{D}\) Donation 5 \( \mathbb{O}\) Other (Specify)  20b. Place of Disposition (Name of ceretely), crematory or other place)  27 \( \mathbb{N}\) Date  28 \( \mathbb{M}\) St. Michael's Ukrainian Cemt	004 Baltimore,	
<b>3alti</b> i	permit. Page Department Importent: t eny injury o		21. Signature of Funeral Service Licenses McCully-Polyniak Fu	neral Home P.A.	
	40 = 0 d		237 E. Patapsco Ave 23a art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resp	<u>, Baltimore, Md</u>	. 21225
	Pnysician	6	shock, or heart failure. List only one cause on each line.  Inmediate Cause (Final disease or condition as the cause on each line.  Broncho Pheumon a a. Broncho Pheumon a	piratory arrest,	Approximate Interval Between Onset and Death
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Division	Attending r death. sctor: After by the fune	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Li	ocation (Street and Number or Re	ural Route Number,
D	itet or urs after rel Dire	Certification:	4   nomicide   building, etc. (Specify)	City or Town, State)	
	To the Hospitet or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and displaced in the compact of the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	ue to the cause(s) and manner as the time, date and place, and due	s stated. to the cause(s)
	To th To th	×	29b. Signature and title of certifier 29c. License number	29d. Date signed (Mont	
	1.		Colvin Clarten 1 D01549	July 4,	2004
	V		Colum Clartenia D0/549  30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)  Colvin Carter 4710 Pennington Avenue Bo	ا بر ایان	2101111
	Ct-	to	31. Date filed (Month, Day, Year)  32. Registrar's Signature	117 more, Md	-21044
	Sta Registi		JUL 0 8 2004. Banes & dones	~.	

	ı		1- State AMEND ITEM #.	State of Maryland PER PHY G833	d / Departmo	ent of Health and	Mental Hygie	0.00
	Physici /Medic		Decedent's Name (First, Middle, Last)		NAOMI LUB		2. Date of Death	Day Year 3. Time of Death 7
	Examin		4a. Facility Name (If not institution, give s	OSPITAL C	TR R	ity, Town, or Location of Dea ANDAULS TO 1	WN, MD	4c. County of Death BALTIMORE
	Funeral Director		5. Social Security Number 215-12-5654 6. Sex	7. Age (In yrs. I	Ast birthday) If Ur Yrs. Mont	der 1 Year If Under 24 Hr. hs Days Hours Min		9. Birthplace (State or Foreign CoMARYLAND
Vand	how El		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Location			10d. Inside City Limits
the Mar	28a-f sl	Director	MD BALTIM  10e. Street and Number	IORE		IMORE Zip Code	10g	1 Yes 2 No
o fler death with the Maryland		Funeral Di	1500 BEDFORD AVE.	#504  12. Was Decedent Ever in U. Armed Forces?  1  Yes 2  No	S. 13. Was De	21208 seedent of Hispanic Origin? (specify Cuban, Mexican, Pue	Specify Yes or No-	USA  14. Race - American Indian, Black, White, etc.
	tural', o	ed by	3 ¼ Widowed 4 □ Divorced  15. Decedent's Educ	If Yes, Give X Year or Dates:	1 ∟ Ye	s 2 🕅 No Specify:	166	Specify: WHITE
d Z I Z I 3-0030	r than "na tre Medic	Completed	(Specify only highest grade	College (1-4or 5+)	(Give kind of life. DO NO	work done during most of wo Tuse retired) ESPERSON	orking	ECHT CO.
should be file	nd Mental Hyg markad othe matic event,	To Be C	17. Father's Name (First, Middle, Last) CHARLES	SODIE		18. Mother's Na JENNI	me (First, Middle, Maid	den Sumame) MANDEL
, Mar.	ulth and 27 is m r traum		19a. Informant's Name/Relationship (Ty) MRS. JUDY HILNBRAN			ess (Street and Number or F		ty or Town, State, Zip Code)  MD 20794
י עב	° = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	lace of Disposition ( emetery, crematory	Name of or other place)	Date 20c	. Location - City or Town, State
DAILLITION	Departmen Important: any injury once.		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License			RUDOMER VERE	TOTAL CONTRACTOR OF THE PARTY O	ROSEDALE, MD N & BROS., INC.
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final	cations that caused the death		REISTERSTOWN node of dying, such as cardia		VILLE, MD 21208  Approximate Interval Between Onset and Death
1	hysician Medical xaminer		disease or condition resulting in death)	Due to (or as a consequ	uence of):	ure perve	GIVE	
petr	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	Due to (or as a consequ	uence of):	(4 - 22 - 4 to 4 to 4 to 4 to 4 to 4 to 4 to 4		
te be exec	physician and the burial-transit	dical Exa	that initiated events resulting in death) Last	Due to (or as a consequ	uence of);			
The law requires that the death certificate be executed	been signed by the ettending ph should be detached for use as th	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 nonths? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 □Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year
w requires that	n signed by	by P	Part II. Other significant conditions con	tributing to death but not resu	ulting in the underlyin	g cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
		Completed						24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
n VII.	this certif al directo	To Be	25. Was case referred to medical examiner?  1  Yes No	ospital: Inpatient 2 🗆	ER/Outpatient 3	Other	ath <i>(Check only one)</i> Home 5 Residence	6 □Other (Specify)
Attending P	uth. :: After ti e funera		27. Manner of e	28a. ate of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
To the Hospital or Attending Physician:	within 24 hours after death.  To the Funeral Diractor: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		tory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
Hospi	24 hour e Funer etely fills	edical (	29a. Certifier Certifying Physics (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occur ion and/or investigat	red at the time, date and plaction, in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
Toth	within To the compl	Me	29b. Signature and title of certifie		MD	29c. License number	29d. I	Date signed (Month, Day, Year) 07/04/20014
	12	5	A MATESHWAR		23a) (Type, Print)	HOPPITAL	RANDAL	LSTDWW MN
ď	Sta Registr		31. Date filed Month Day, 2004	32. Registrar's Signat	ture do	10311111	1 Chalvida	, ,

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 10:30 A **Physician** July 1 2004 Vicki Lee Lindamood /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Glen Burnie 1024 Cayer Drive, Apt. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Jun. 17, 1 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 🛣 F 1950 Washington DC Yrs. 54 215-54-9252 **Director** Usual Residence of Decedent 10d, toside City Limits 10c. City, Town or Location with the Maryland 10a State 10b. County ir than "natural", or items 23e or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 🔀 No Glen Burnie Anne Arundel Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 United States 1024 Cayer Drive, Apt. 803 filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: tt Yes, Give Year or Dates: δ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Etementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Aviation Ramp Agent 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Mariam Gilliam William Kenneth Herrell ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health ar Important: If itsm 27 is any injury or othar trau QDCB. 3339 Valley Lee South, Laurel, MD 20724 Allison Catucci Sister 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition meadowridge x Burial 2 ☐ Cremation 3 ☐ Removal from State 7-7-2004 Elkridge, MD ☐ Donation 5 ☐ Other (Specify) Memorial Park 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 21. Signature of Funeral Service Lice 2719 Hammonds Ferry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death tmmediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown cate has been signed by the page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 3 ☐ Probably 4 ☐ Unknown 2 🗆 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 1 ☐ Yes 2 No certificate : After this certifica funeral director, r 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 6 ∏Other (Specify) 2 ER/Outpatient 3 DOA 4 Nursing Home 1 Inpatient 5 Residence Medical Certification: To 1 Yes 28d. Describe how injury occurred 28a. Date of tnjury (Month, Day Year) 28c. tnjury at Work? 27. Manner of Death 28b. Time of 5 Pending investigation 2 🗌 No 1 Yes hours after death. 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) npletely within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (ttem 23a) (Type Print) RUN PHAI 6 32. Registrar's Signature 31. Date fited (Month, Day, Year)

JUL 0.8 2004 State Registrar

DHMH 17 Rev 1/2001

2004

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PATRICIA LOUDEN

### Arthur Lee 04-4319 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

319	) Lee		1 - For State Registrer	State of Ma		d / Depa	artmen	t of H	lealth a			giene	ible.	
			Registrer  1. Decedent's Name (First, Middle, La	and)		Cei	rtificate	e of L	Death			Reg. No	04	21372
	Physici	ian	Arthur L.								. Date of Dea	Day	Year	8. Fime-of Death.
	/Medi Examir		4a. Facility Name (If not institution, given	Lee			4h City	Town or	Location of		July 2	2, 2004 4c. Count	v of Door	9:03 A M
1	Exami	iei	1123 Hewitt Way				vo. oky,		ltimor					1
	Funeral		5. Social Security Number 6. S		e (In yrs.	last birthday)	If Under	1 Year	If Under 24	4 Hrs. 8.	Date of Birt	h	V/A 9. Birtl	nplace (State or Foreign
	Director		219-30-3480	1 <b>X</b> M 2□F	69	Yrs.	Months	Days	Hours	Min.	Month, Day	y, Year)	Co	Maryland
	and *		Usual Residence of Decedent  10a. State 10b. County	-	10c Cit	y, Town or Lo	cation							
	Aaryla I sho	ō			100. 01.	y, 10411 01 LC								10d. Inside City Limits 1 Yes 2 □ No
	286-1	ect	Maryland N/	4			10f. Zip	timo.	re			10= Cities	14/5-1-0-	147
	3a or		1123 Hewitt Way				101. 210		1205			10g. Citizen of		
	death	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	Was Deced			in? (Specif	y Yes or No-		L. S.	A.
9	after or ite	F.	1 X Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 □ N If Yes, Give	10		tYes,spec I⊡Yes 2			Puerto Ric	an, etc.)		ick, White	, etc.
003	72 hours after death with the Maryland natural', or items 23a or 28e-1 show dical Evantinar must be rodified at	d by	3 Widowed 4 Divorced	Year or Dates:								Speci	y: U	hite
5-	"natu	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Deced (Give	lent's Usua kind of wor	l Occupa k done d	ation Au <i>ring most c</i> )	of working		16b. Kind of B	lusiness/l	ndustry
12	within ene. than "	dmo	Elementary/Secondary (0-12) 12th Grade	College (1-4or 5	+)	ure. L	Cler		,		į	01		
0 2	be filed within 72 hours after death with the Marylan tial Hygiene. ad other than "natural", or items 23a or 28e-1 show event, the Medical Evandrant must be rediffed at		17. Father's Name (First, Middle, Last	)			cie		18. Mother's	s Name (F	irst, Middle.	Maiden Surnai	ippin	<u>g</u>
<u>a</u> n	should be id Mental marked of metic ev	To Be	Howard Lee								iller		,	
Maryland 21215-0036	s 1 and 2 should f Health and Men item 27 is marke other traumetic		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	g Address	(Street a				r, City or Town	State, Z	p Code)
	and 2 alth a 127 is		Patrick Lee (Bro	other)										
ore	es 1 a of Hea fitem r othe		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Demousliferer Chate	20b. P	lace of Dispo	sition (Nam	e of her place	9)	Date	9	. Maryk 20c. Location	- City or T	own, State
<u>Ĕ</u>	Pages Tent of I ant: If its ury or o		`4 □Donation 5 □ Other (Specif	y)	Вау	view C	remat	ory	7/	3/200	)4 i	Baltimo	re.	Maryland
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licer	nsee		22	. Name and	Address	s of Facility	Schi		Funera		
	<u>vo</u> = 9		My Day	dans		33	31 Br	ehms	s Lane	e, Bal	ltimor	e. Mary	land	21213
5	Physician		23a. Part. Enter the disease, or constack, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin			-			4		rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a										
b		F	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequ	ience of).								
	uted 1 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
Ć.	execuna and ial-tra	Еха	resulting in death) Last	Due to (or as a	consequ	ence of):								
8760,	sate be executed oblysician and the burial-transit	cal	(	d										
9	ntifica ng ph as th	e	IFFERNS.											
Вох	Attending Physician: The law requires that the death certificate be executed robath.  robath.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth			Ectopic pre	anancy				23d. Da	te of deliv	ery
О. П	e dea the at ned fo	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at i			Other (spe					Mo	nth	Day Year
P.O.	res that the de signed by the a I be detached f			antabution to dooth bu	t ===t -===	dalam in the con-	4.4				00 0			
ds,	signe signe	l by	Part II. Other significant conditions of	1		_	derlying car	use giver	n in Part I.					he cause of death?
OC	w requir been si should I	etec	Emphysema	lung car	cer					-		es 2□No	3 Prol	oably 4 □Unknown
Records,	has l	Completed			-						24a. Was a autops	y i	prior to co	psy findings available mpletion of cause of
	ician: Th certificate rector, pag		25.11								perform		death?	2□ No
Division of Vital	Physician: The I this certificate ha al director, page	o Be	25. Was case referred to medical examiner?  1 XYes 2 □ No	Hospital:				Other			heck only on			
of	Phys ar this aral di	T: To	27. Manner of Death	1 ☐ Inpatier 28a. Date of Injung (Month, Day		ER/Outpatient 28b. Time of		1	4			once 6 COth		wat scene
on	rding F tth. : After s funer	tior	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		Year)	Injury	М	c. Injury : Work?	es 2 □No			or algory occur	ou	
S	Atter r dea ector by the	ifice	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ry - At hor	me, farm, stre	et, factory,			28f.	Location (St	reet and Numb	er or Rura	i Route Number.
á	el or s afte	Certification:	4  Homicide determined	building, etc.	. (Specify,	)	•				City or Towr	n, State)		
	Hospitel 4 hours a Funeral [ tely filled		29a. Certifier 1 Certifying Ph	ysician: To the best o	f my knov	vledge, death	occurred at	t the time	, date and p	place, and	due to the ca	ause(s) and ma	nner as s	tated.
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	one) 2 Medicel Exam	niner: On the basis of and manner stat	examınatı	ion and/or inv	estigation, i	n my opi	nion, death o	occurred a	t the time, da	ate and place, a	and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	01 0				License			25	96. Date signed		
			Jasho?	Jely	M	)	0	.C.M	1.E.			July	2, 2	2004
	4		7/1	completed cause of de		23а) (Туре, Р								
	1			where N. V	-	1170	111	Penn	Stre	et, B	Baltimo	ore, Ma	ryla	nd 21201
	Sta Registra		31. Date filed (Month, Day, Year) 8	2004	o Signati	2	de	bour	h					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** MOORE DARRYL 2004 01 5.31AM 4b. City, Town, or Location of Death /Medical 4c. County of Death 4e Fecility Name (If not institution, give street end number) Examiner Genesis N.H. Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country)
 MQ . 6. Sex 1 2 M 2 ☐ F 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Min. Months Hours 37 212-92-0394 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County Item 27 is marked other than "natural", or heme 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No Director Md. BALTIMORE Dundalk 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hyglene.
Important: If them 27 Is marked other than "man any injury or other traumation." 709 S. Avondale Rd. 21222 IISA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 1 X Never Married 2 Married 1 ☐ Yes 2 HNo Specify: Specify: Black ፩ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales llth grade Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Clarence W. Moore Shirley Moburry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 721 E. 22nd Street, Baltimore, Md Shirley Moore Mother 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Sacred Heart of Jesus 7-8-04 Dundalk, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part1. Enter the diseese, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical STAGE THIMON Examine Due to (or es a consequence of): Examine ettending physicien end for use as the bunal-trensit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medicai Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed hes 1□Yas 2□N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No this 28c. Injury at Work? 27. Menner of Death 28d. Describe how injury occurred 5 Pending investigation Naturel 1 Yes 2 No after death. 2 Accident 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D intifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) end manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number D0053150 Supre MD 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) POBOX 6303 ELLICOTT 474 GUPTA 5 h A RUNMALA 31. Dete filed (Month, Day, Year) 32. Registrer's Signature

Registrar

Callera.

JUL 0 8 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year ETHEL MIMS 30 4:00p. June 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
| If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Manor Care Nursing Home 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05 23 Birthplace (State or Foreign Country) **Funeral** 1□M 2🛱 F Yrs. Director 213-14-8353 89 NC Usuel Residence of Decedent 10c. City, Town or Location 10a. State 10b. County or 28a-f show 10d. Inside City Limits ir than "natural", or Itema 23a or 28a-f shov I've Medical Examiner i uni be nutified at Director XXYes 2 ☐ No MD NA Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2044 North Bentalou Street 21216 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Yes XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ 3∰Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 3rd grade Domestic Private na permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other sny injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Roland Holley Abraham Holley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gay Jones-Daughter
20a. Method of Disposition 2044 North Bentalou Street, Balto. Md 20c. Location - City or Town, State YSBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 7/6/04 Baltimore, Md 21. Surante of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) d **Physician** Oue to (or as a consequence of): /Medical Examiner ement Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed rosvan and I-tran Due to (or as a consequence of) attending physicien a for use as the burial Physician/Medical man IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 10 No Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 Yes 2 No 2 this is 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Certification: or Attending s after dec. 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Division of Vital Records, P.O. Box 6

Maryland 21215-0036

Baltimore,

DIVIS

To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by the

8

Registrar

Medical

State 31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title-of certifier

Year) 32. Registrar's Signature

0 8 2004 Server

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

War

& Spark

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

3146

29d. Date signed (Month, Day, Year)

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It Inte 308 Bult. MD 21201

DHMH 17 Rev 1/2001

MD

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day MERRILL Month 6:30 AM. /Medical 04 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Rehabilitation Extended care Baltimore
If Under 1 Year If Under 24 Hrs. N/A 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 4281 Days 1**X** M 2□ F Director Sept 5.1928 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location item 27 Is marked other then "neturel", or Items 23e or 28e-1 show other treumetic event, the Madical Eventines in an integral by 10d. Inside City Limits Marvland N/A **Baltimore** Director XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3634 Roland Avenue 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

X \ Y \ Yes \ S ive Yes or Dates \ 1950-53 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. soft Health and Mental Hygiene. 1 ☐ Never Married 2√ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes XXX No Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Greenspring Dairy 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Merrill Carrie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daughter Cynthia L. Michael 23950 Arunah Way Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ö XX Burial 2 Cremation 3 Removal from State Department of Importent: If any injury or once. Maryland Veteran Cem 7/8/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest,MD meral Service Livensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Physician patocellular Carcinoma o months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 2 🗆 No 1 ☐ Yes 1 🗆 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**O 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Aithin 24 hours after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 34359 (OHIO) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 och Raven Boylevard, Baltimore 21218 Tohu S. AH, M.D. 32. Registrar's Signature Registrar

NORLIS, Edward

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For Amend Items Sigte of Maryland Control of Degation and Mental Hygiene Certificate of Death  Registrar  Registrar	0.00
	Dhusia		Decedent's Name (First, Middle, Last)     2. Date of Death	3. Time of Death
	Physic /Medi	cal	al EDWARD K. NORRIS	2004 1105AM
1	Exami	ner	CHITY A MARTIN CONTROL WAS AND THE	County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foreign Country)
	Director			948 MD
	ryland how		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	he Ma Se-f	Director	MD NA BALTIMORE	1X Yes 2 No
	with 1			zen of What Country?
	death	Funeral	823 MARTIN LUTHER KING BLVD 21201  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	USA 14. Race - American Indian,
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Maryland 21215-0036	should and Men s marke umetic	2	F INDENA IEII	TIFORD Town, State, Zip Code)
	and 2 ealth a m 27 Is		MRS. NOREEN NORRIS (SPONSE) 823 MARTIN LUTHER KING JR. BLBD	21136 21201 BALTIMORE, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents if item 27 is marked other then "naturel", or items 23a or 28e-f show any injury or other treumetic svent, the Medical Erant and must be notified at ances.		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Loc	cation - City or Town, State
Ħ	artmer ortent injury		Of Circulation of Francis Constitutions	ONSVILLE, MD
ä	permit. Departr Importe any inju		22. Name and Address of Facility WYLIE FUNERAL  638 N. GILMOR STREET BALTIMORE	
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Rec	The law aate has l page 2 s	Completed	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
		ø	25. Was case referred to medical	1 ☐ Yes 2 ☐ No
> =	Physicien: r this certifica ral director, p	ToB	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6.	Sother (Specify) hospice
Division of	of or Attending Parter death.  Director: After the in by the funera	Certification:	27. Manner of Death  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  28c. Injury at Work? Work?  28d. Describe how injury of Injury Work?	occurred
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	Registra			

# ANNA Y. POLAL Baltimore, Maryland 21215-0036

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should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland and Mental Hyglene.  In arked other than "netural", or items 23a or 28e-f show umatic event, the Mydlight Entitle or filed.	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 1 Widowed 4 Divorced	12. Was Decedent Armed Forces?	Ever in U.S.		as Decedent of H Yes, specify Cuba		in? (Specify Yes or N Puerto Rican, etc.)	10-	14. Race - Ame Black, White Specify:	
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		' 4 □Donation 5 □ Other (Sp 21. Signature of Funeral Service L		ADATH		URUN CEN		/6/2004 / SOL LEVII		LADELPH	
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Λ		30. Name and address of person v	who completed cause of d	leath (Item 23a	a) (Type, P	rint)					

State Registrar

		For State	State of	of Maryla		artmen <i>rtificat</i>			d Mental Hy	/giene	е		
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		Gilchrist Cente	r				Tows				Balti	more	2
Funeral Director		2.0 00 0102	× □M 21√2 F	7. Age (In yrs	s. last birthday) Yrs.	If Under Months	Days	If Under 24 H Hours M	Hrs. 8. Date of B Min. (Month, D	irth ay, Year) 25,19	914	. Birthpla Counti Maru	ace (State or Foreign ry)  Land
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h the	Director	10e. Street and Number	A			10f. Zip				10g. Ci	tizen of Wha	at Counti	
23a c		2303 Reliance Co	ourt				21	084			U.S.A	١.	
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212 d withii giene.	mo du	Elementary/Secondary (0-12)  12th Grade	College (	1-4or 5+)		omemo					Own	Hama	<b>)</b>
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ore, Maryland 212 is 1 and 2 should be filed with the sells and Mental Hygiene, them 27 is marked outer than other traumatic event, trans		19a. Informant's Name/Relationship (7)		1 ( )					Rural Route Numb				
e, N 1 and 1 and Health em 27 ther tr		Mrs. Valerie Peed	c (aaug		Place of Dispos	Reco	cance	. Ct., .	Jarrettsi Date				
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hyginary Informant: If them 27 is marked other than "natural; or any Injury or other traumatic event, the Medical Exampone.		<ul> <li>4 □ Donation 5 🛣 Other (Specify)</li> <li>21. Signature of Funeral Service Licens</li> </ul>	ee ENLOMD	ment H	rghvrew	Maus Name an	OLEUI Id Address	m 7/6	08/2004 Schimunek	Fac	eston	, Ma	rykand •
Baff permit. Departi		Buan a-lu	elle		9	705 E	Belai	r Rd.,	Baltimor	ie. N	10 212	поте 36	۵
		23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that one cause on e	caused the dea	ath. Do not ente	er the mod	e of dying	, such as card	fiac or respiratory a	rrest,		F	Approximate nterval Between
Physician		tmmediate Cause (Final disease or condition	. Y	neta	static	. B	reas	st Co	meen				nset and Death
/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):								
£	er	Sequentially list conditions, if any, leading to immediate	Due to	(or as a conse	quence of):								
2 de la company	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
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		IF FEMALE:	Da If you and	loomo of proper									
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the d	nysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□Unkn		300	Other (Spi							
15, P.O. I les that the designed by the a be detached f		Part II. Other significant conditions con	ntributing to de	eath but not re	sulting in the un	derlying ca	ause giver	in Part I.	23e. Did 1	obacco u	se contribut	e to the	cause of death?
Becords, he law requires the law seen signe to should be on the seen signed.	Completed by	Dementia							_ 1 🗆	Yes 2	No 3□	] Probab	iy 4 □Unknown
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Of Of Physical dildi	: To	1 Yes 2 No	28a. Date		ER/Outpatient 28b. Time of			4 🗀 Nursing	Home 5 ☐ Resi		Other (S	Specify)	Hospice
PAL ion of maing Ph	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Mon	th, Day Year)	Injury	м	8c. Injury a Work? 1 ∐ Ye	s 2 □No	Zod. Describe	now injury	y occurred		
Division of Vital  Division of Vital  or Attanding Physician: The after death: The Director: After this certificate din by the funeral director, pa	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place buildi	of Injury - At h	nome, farm, stre	et, factory	, office		28f. Location (. City or To	Street and wn, State)	d Number o	r Rural A	Poute Number,
Division of Vita  Division of Vita  To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Exami	ner: On the ba	best of my kn asis of examinater stated.	owledge, death ation and/or inve	occurred a	at the time in my opir	, date and pla nion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner place, and	r as state due to th	ed. e cause(s)
To tl withii To th comp	Σ	29b. Signature and title of certifier	1	2		29c.	. License r	number			e signed (M		
		M Anthony	Mil	4.0	no	0	25	205		ししり	7 3,0	200/	se .
5		30. Name and address of person who co	BMC			ch.	arle	St. 1	Belto.				
Sta Registr	_	31. Date filed (Weath, Day, Year) UL 08 2004	35 R	egistrar's Sign	ature	don	K						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 12:08AM 200 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Bal-If Under 1 Year HOPKINS more 0( If Under 24 Hrs. 8. Date of Birth (Month, Day) Dec 15 Age Birthplace (State or Foreign Country) Days Min 215-82-3295 1 ☐ M 2 💢 F Months Hours 46 Yrs Md Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Carrol1 Mt. Airv 1 TYYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21771 1005 Main Street 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Yes 27 No f Yes, Give Y fear or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) insurance insurance agent 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John T. Farinholt Mary C. Wurtzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Dogstreet Rd., Keedysville, Md 21756 Todd Parks (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Memorial 7-10-04 Marriottsville, Md \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee ▶ Paige Harg Box 195 Sykesville, Md 21784 P.O. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 23d. Date of delivery ic pregnancy Month Day Year (specify) ng cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 🗆 No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 1 Yes 26. Place of Death Check only one Other: DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Hospital or Attanding Physician: The law requires that the death certificate be exacuted Division of Vital Records, P.O. Box 68760, After after death filled in by the

**Physician** 

/Medical

Examiner

10a. State

Md

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23e or 28e-f show

Baltimore, Maryland 21215-0036

itam 27 Is markad othar than "natural", or Itams 23a or 28a-f show othar traumatic avant, If a Madical Examinar must be notified at

5

permit. Page Depertment of Important: If any njury or once.

**Physician** 

/Medical **Examiner** 

Be Completed by Funeral Director

2

icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):
nysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopi  4 Pregnant at time of death 5 Other
o Be Completed by Physician/Medical Examiner	Coronary Stroke hyperchole 25. Was case referred to medical	Artery Dise
ation; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M
Certification; To	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)
dicai (	29a. Certifier (Check only one)	sician: To the best of my knowledge, death occur ner: On the basis of examination and/or investigat and manner stated.

 Location (Street and Number or Rural Route Number, City or Town, State) tory, office

ed at the time, date and place, and due to the cause(s) and manner as stated.

tion, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

D 0059

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGNIESZKA ARDELT, MD

WOLFE ST. BALTIMORE, MD 21287

Registrar

Med

29b. Signature and title of certifier

32. Registrar's Signature

ORIGINAL

600N

DHMH 17 Rev 1/2001

To the Hospital within 24 hours at To the Funeral D

David Duane Patton 04-04 RPD

143	.3		For State	-	partment of Health and ertificate of Death	Mental Hygi	•		
	Physici		Registrar     Decedent's Name (First, Middle, Last     David Duane Pa		orimodic or bodin	2. Date of Death July 5,		3. Time of Death	
ir e	/Medic Examin		4a. Facility Name (If not institution, give 5522 Strawbridge 1		4b. City, Town, or Location of Deat Sykesville		4c. County of Deeth Carroll		
8	Funeral Director		BIE B1 1705 .	7. Age (In yrs. last birthda M 2 F 76 Yrs.	Months   Davs   Hours   Min.	8. Date of Birth (Month, Day, NOV 1 19	9. Birthpi 927 Md	lace (State or Foreign try)	
	Maryland I-1 show	tor	Usual Residence of Decedent  10a. State 10b. County  Md Carro	oll Elderst			10	0d. Inside City Limits 1 ☐ Yes 2 🎇 No	
	h with the 13s or 28e st be noti	ai Director	10e. Street and Number 5522 Strawbridg	ge Terrace	10f. Zip Code 21784		g. Citizen of What Coun JSA	try?	
USP	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or Items 23s or 28s-f show event, the Medical Evaniner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1√€Yes 2 □ No WWII 1/4°es, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:	specify Yes or No- to Rican, etc.)	14. Race - America Black, White, a Specify: whi	etc.	
Baitimore, Maryland 21215-0036		Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	(Gi life College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of wo b. DO NOT use retired)	rking	6b. Kind of Business/Ind	lustry	
yland	be d la	To Be C	17. Father's Name (First, Middle, Last) Roy C. Patton		Bessie				
, Mar	nd 2 ulth a 27 is r treu		19a. Informant's Name/Relationship (T) Yvonne Patton (spo	ouse) 5522	ailing Address (Street and Number or Ric 2 Strawbridge Terra	ace, Elde	rsburg, Md	21784	
imore	permit. Pages 1 a Department of Hee Important: If item eny injury or othe		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ I  4 ☐ Donation 5 ☐ Other (Specify,	Removal from State R110 Pig	sposition (Name of rematory or other place) Ige Cemetery 7-9-	-04	Oc. Location - City or To Thurmont, Mo	d	
Balt	permit. Departi Import eny inj once.		21. Signature of Funeral Service Licens	Haigh	22. Name and Address of Facility $H_{a}$ P.O. Box 195 Sykes	sville, Mo	1 21784	Chapel	
	bath certificate be executed attending physician and attending physician and for use as the burial-transit	cai Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	eutomobile exh	n		Approximate Internal Between Onset and Death	
O. Box 68	The law requires that the death certificat tte has been signed by the attending phy page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	ry Day Year	
J.	quires that n signed b	by	Part II. Dther significant conditions co	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to th s 2 ⊠No 3 □ Proba		
Vital Records		Completed				24a. Was an autopsy perform	ed2 prior to con death?	osy findings available inpletion of cause of 2 No	
<u> </u>	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1XX('es 2 \subseteq No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	Othor	ath <i>(Check only one</i> fome 5 ☐ Resider	nce 6 XOther (Specify	At Scene	
DIVISION OF	Attending death. ctor: After y the fune	Certification: T	27. Manner of Death  1  Natural 5  Pending investigation  3  Suicide 6  Could not be determined	28a. Date of Injury  (Month, Day Year)  28b. Time  20c.  28b. Place of Injury  28b. Time  20c.  28b. Place of Injury  28b. At home, farm, by ilding, etc. (Specify)	e of 28c. Injury at Work?  3 o p M 1 □ Yes 2 ⊠No	28d. Describe how Cov runni 28f. Location (Str	w injury occurred  The cluses  Beet and Number or Rural	L garus	
1	To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b	edical Ce		vsicien: To the best of my knowledge, de iner: On the basis of examination and/or and mennal states		and due to the car	use(s) and manner as sta	ated.	
	To the within 2 To the complet	Med	29b. Signature and title of certifier	,	29c. License number	29	d. Date signed (Month, L		
1	F 111	2	Jaska 35	rearly MD	O.C.M.E.	7755-081735-6	July 6, 200	04	
1	) W.	-		ompleted caused death (Item 23a) (Tyr Lonbery M.D	111 Penn Street,	Baltimore	e, Maryland	21201	
Ì	Sta Regist		31. Date filed Wanth Oak Year 004	2, Ragistrar's Signature	Sports				

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** 4:30P 2004 Catherine M. Reichelt Jul. S /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat 4c. County of Death Examiner Care n wot VZNOT nat -CK HIMOT If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 X F Months Davs Hours 98 Director 1905 Washington DC July 213-74-3116 Usual Residence of Decedent with the Maryland 10a State 10b County 10c, City, Town or Location 10d Inside City Limits item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, it a Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 717 Maiden Choice Lane ST 101 21228 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify: Specify à 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any lighry or other traumatic event any lighry or other traumatic event ang. Be Joseph F. Marques Sarah A. Gorman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles Reichelt / Son 10300 Greenacres Drive, Silver Spring, MD 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 7/9/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or own lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only necroused on each line. Approximate Interval Between Onset and Death Immediate Cause (Final onaestiv **Physician** resulting in death) /Medical Due to (or as a nsequence of) Examiner Hortic enos! Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a nonsequence of Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) the attending physicien Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day Year Month in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 2 🗆 No 3 Probably 4 CUnknown 1 Yes Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy 2 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 Ho 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Ihe I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature an a title of who completed cause of death (Item 23a) (Type, Print) Yaiden Choice Lane, Baltimore, MD21228 DNE 111 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 08 **ZUU4** Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #17&18 PER FH C835 CO 1/108/04/01 PREATH 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Hugh Muir Roper** Month July 4, 2004 8:10 p.m<sub>M</sub> **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 82 Yrs 219.07.2026 August 9, 1921 Director Maryland Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County , or Itema 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 20No Montgomery Silver Spring Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 U.S.A. 3142 Gracefield Rd.; Apt 411 Funerai 12. Was Decedent Ever in U.S. Ampéd Forces? 1 X Yes 2 □ No 1 I Yes, Give 1 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Guban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or ite any injury or other traumatic event, the Medical Externing 1 ☐ Never Married 200 Married 1958 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 White Specify þ 1962 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) United States Air Force Elementary/Secondary (0-12) College (1-4or 5+) Officer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unknown WALLACE ROPER Lila unknown AYLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3142 Gracefield Rd.; Apt 411 Silver Spring, Maryland 20904 Ms. June Roper Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation
4 Donation 5 Other (S 3 Removal from State 07/06/2004 Baltimore, MD **Bayview Crematory** 5 Other (Specify) 21. Simature of Funeral Service Licensee 22. Name and Address of Facility
Slack Funeral Home, P.A Willer 170053, 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 2 🗆 No 1 ☐ Yes 2 No 1 🗌 Yes or Attanding Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To t 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury within 24 hours after control to the Funeral Director: Aft 2 🗆 No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title Name and address of erson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 432. Registrar's Signature State 0 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Stanley Anthony Radvan-Ziemnowicz July 3, 2004 8:10A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Potomac Valley Nursing Home Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country)
 Poland **Funeral** 8. Date of Birth (Month, Day, Year) Hours 1 ☑ M 2 □ F Days Months Min Yrs. Director 220-38-4031 91 March 12,1913 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Madical Examiner must be notified at Director 1 Yes 2 □ No Maryland Montgomery Rockville 10e, Street and Number 10f Zin Code 10g. Citizen of What Country? death with or items 23a or 1235 Potomac Valley Drive Funeral 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 2 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physician Medical Pages 1 and 2 should be filed vent of Health and Mental Hygie int: If Item 27 is marked other t (unknown) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) (unknown) Be ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1000; Concord Campus #3; Athens, WV 24712-100 other t Christopher Ziemnowicz/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of limportant: If Its any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Loudon Park Crematory 07/08/2004 Baltimore, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Funeral and Cremation Center Chr 1040 Rockville Pike; Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) mentio ean /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) P.O. the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Inknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed certificate 1 Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 2 1 Inpatient 2 ER/Outpatient 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA this Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide To the Hospital Prestifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MU) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) esearch BLVD suite 330 MENDHIRAT 2401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0 8 2004

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 0915 AMM MARGUERITE M. ROTHGEB Ju<sub>1</sub>y 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 29975 St. James Way Princess Anne Somerset If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🐼 F 67 216 34 1794 09-17-36 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "neturel", or Iteme 23s or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Somerset Princess Anne Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21853 U.S. 29975 St. James Way Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked othe any injury or other tredmatic event, 9068. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rae Pennington Henry Laque ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21236 7 Leslie Avenue Joseph Rothgeb / son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/6/2004 Loudon Park Cemetery Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lich 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner M Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 48098 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 HALL HIGHWAY, CRISFIELD, MD 2/8/17 KARUMBUNATHAN, VIJAY 31. Date filed (Month, Day Year) 3. Registrar's Signature State Registrar

Amend Item #17&19a per informant G835 9/1/04 tas Amend Item 1 per Dr., C834,08/10/04dhb Ensure All Copies Are Legible. 1- State Registrar 10eState of Maryland Department of Health and Mental Hygiene Certificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Martin H. Raila Month Day Year **Physician** Martin H. Railia 25 JUNE 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number **Funeral** 1**∑**M 2□F 81 Yrs. Director June 9, 1923 Maryland 217-18-9514 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Example must be notified at MD Baltimore 1 ☐ Yes 2√ No Baltimore 10e. Steel and Number ther Blvd 8000 Walther Blvd #3014 10g. Citizen of Whal Country? 10f. Zip Code with 21234 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Item 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 148-49 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) educator education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin Railia Martin Raila Emilija Janonis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) May T. Raila / spouse 8800 Walther Blvd #3014 Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Stete eny injury or c 1 Burial 2 Cremation 3 Removal from State 4 N Donation 5 Other (Specify) 21. Signature of Funeral Service bicensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 rd. Enter the disease, a complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ick, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease. Immediate Cause (Final disease or condition resulting in death) PULMONARY INTERSTITIAL 10445 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the attending physician and hed for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð pe 1 Yes 2 No 3 Probably 4 Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 2 No 1 ☐ Yes 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Pis 28a. Date of Injury (Month, Day Yeer) To the Hospital or Attending Pl within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1x Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certified AT 2438946 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PKWY 201 E. UNIVERSIT A-PARHAR UMH 32. Registrar's Signature 31. Date filed (Month, Day, Year)
JUL 0 8 2004 State Registrar

DHMH 17 Rev 1/2001

Registrar

			1 - For Stata Registrar	State of Marylan		artment of F		_	giene Reg. NO: 11 11 :	01007				
			Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death				
	Physici		Guy Win	ford Shepard				July	3, 2004	7:30A M				
}	/Medie Examir		4a. Facility Name (If not institution, give		-	4b. City, Town, o	r Location of Deat		4c. County of					
	LAdiiii	ici	428 Reading Avenue			Rocky	ville		Monte	omerv				
	Funeral			7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs Hours Min.	8. Date of Bir	•b	Birthplace (State or Foreign Country)				
	Director		212-28-2266	<sup>M 2□ F</sup> 72	Yrs.	Months Days	FIGUIS WITH	Jan. 2	2, 1932	Virginia				
	pu ,		Usual Residence of Decedent	40. 00						I dod I wide City Limite				
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	e 23	by Funeral	428 Reading Avenue	12. Was Decedent Ever in U.	C 12 1	208		Specify Ves or No	United S	tates American Indian,				
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21215-0036	within 72 hours efter death with the Maryland ene. than "natural", or Iteme 23a or 28e-f show he Medicel Examinat must be notified at	ted	15. Decedent's Edu		16a. Deced	lent's Usual Occup	pation		16b. Kind of Busi	ness/Industry				
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21	d with	Completed	6	,	Ca	rpenter			Constr	uction				
b	e file al Hy lothe vent,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame)					
<u>Ja</u>	Menta Menta arked	L O	William Shepard				Dora Hor	naker						
Maryland	s 1 and 2 should be filed within 72 hours efter death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship (Ty		19b. Mailir	g Address (Street	and Number or R	ural Route Numbe	er, City or Town, St	ate, Zip Code)				
≥,	and n 27 ner tr		Susan Laurine Daug				Run; I		e, MD 217					
ore	of H		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ R		lace of Dispo emetery, cren	sition (Name of natory or other plac	ce)	Date	20c. Location - Ci	ty or Town, State				
Ē	Pag ment ent: ury c		'4 □Donation 5 □ Other (Specify)	Lo		ark Crem			Baltimor					
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: if them 27 is marked other than 'any injury or other treumatic event, I'm Me once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Simple Tribute Funeral and Cremation Cente 1040 Rockville Pike; Rockville, MD 20852  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approxim											
			23a. Part1. Enter the disease, or compli	cations that caused the death						Approximate Interval Between				
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	and trans	Examiner	that initiated events resulting in death) Last											
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Ö	w requir been si should	Completed						24a. Was	an 24h Wa	re autopsy findings available				
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Division	I or Attending after death. Director: After I in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho	me, farm, str	eet, factory, office				or Rural Route Number,				
Ö	afte safte	Certification;	4 🔲 Homicide	building, etc. (Specify	")			City or Tov	vn, Statej					
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical (	29a. Certifier 1 ← Cartifying Phys (Check only 2 ← Madical Examin	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the tir restigation, in my o	me, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)				
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			1 James	1	V	D3789	91		July 6,	2004				
	1		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,				July Us					
	)		Amit Rajvanshi, MD	9801 Georgia	a Aven	ue; Suite	e 118, Si	ilver Sp	ring, MD	20902				
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signar	ture	1								
	Registi	rar	<b>連近 0:8:2004</b>	District	7 4	oails								

Physicia	an.	Registrar  1. Decedent's Name (First, Middle, La	_	Ce	rtificate of	Death	2. Date of D		av V	(ear 3. Time of Di	B B Seath
/Medic		Donald Renault	Smith				July	1, 2	004	6:58	A.M
Examin	er	4a. Facility Name (If not institution, given Southern Maryland			4b. City, Town, o	ath		c. County of rince	Death George's		
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Sa-f show	ctor	Maryland Ch	arles	. City, Town or L	ocation Waldo	rf				10d. Inside City	
23a or 21	ai Dire	10e. Street and Number 2255 Hope Circle			10f. Zip Code 20601				tizen of Whated St	•	
i result and weller rygelies of thems 23a or 28a-f show times 21s marked other than "natural", or leams 23a or 28a-f show other traumatic avent, the Medical Exam not must be modified at	by Funeral Director	11. Marital Status  1 ★ Never Married 2  Married  3  Widowed 4  Divorced	12. Was Decedent Ever Amed Forces? 14∑Yes 2 ☐ No If Yes, Give Year or Dates: Vi		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No		Specify Yes or N into Rican, etc.)	0-	Black,	American Indian, White, etc. African—Ame	eri
an "natu Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Dece (Give life.	edent's Usual Occup kind of work done DO NOT use retire	pation during most of world)	16b. K	(ind of Busir	ness/Industry		
othar than				Contra	actor	1			E-Emp1	.oyeed	
Is marked of	To Be	17. Father's Name (First, Middle, Last, John H. Smith, Sr					ame (First, Middle Lowery		n Sumame)		
27 Is ma trauma		19a. Informant's Name/Relationship (Constance Jones	Турө, Print) (Sister)	19b. Maili 9511	ng Address <i>(Street</i> <b>Minstead</b>	and Number or F	Rural Route Numb	ber, City o	or Town, Sta	ate, Zip Code) 0151	
If itam		20a. Method of Disposition		b. Place of Dispo	osition (Name of	Į.	Date	20c. L		ty or Town, State	
tant:		1 ☐ Burial 2X Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specification )		Laurel, Marylan							
Important: If itam 27 Is any injury or other tree.		21. Signature of Funeral Service Licer								l Director land 21133	
/sician		Immediate Cause (Final	one cause on each line.			ng, such as cardia	ac or respiratory a	arrest,		Approximate Interval Betwee Onset and Dea	en
ysicia e bur	cal Exa	-	14. /	y cemic sequence of): Dia se sequence of):		ng, such as cardia	ac or respiratory a	arrest,		Interval Between	en eath
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			Amend Item	#8State-of-M	aryland	14 PS/R3	ytment of F tificate of	Health and M		1001	01 0	1000
			1. Decedent's Name (First, Middle, La	ist)			lilicate or	Deaur	2. Date of Death	- No.	147	3. Time of Death
	Physicia /Medic		Charles F.	Scannel1					Month Tuly	Day	Year	5:40 AM
7	Examin		4a Fecility Name (If not institution, giv	/ /				4b. City, Town, or Lo		4c. County		
				ty HOSPITA		e time ato	If Under 1 Year	BAITIM If Under 24 Hrs.	10Re	n <del>/ 97 / 1</del>	OZNA	
	Funeral Director		5. Social Security Number 6. S 212-36-0541	Sext 7.Ag 1—gM 2□F	ge (In yrs. Ia 6.5	ast birthday)	Months Days		8. Date of Birth (Month, Day, Y	/ear) 2004	Country	
	× ×		Usual Residence of Decedent						<del>oche zi,</del>	-4-6-6	Maryla	and
	arylen show	_	10a. Stete 10b. County		10c. City,	Town or Loc						Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-f	Director	Maryland N/A			ратт	imore		100	075		V7-35 (1 - 1 - 1 V
	with the or it		10e Street and Number 524 N. Charles Str	cost			10f. Zip Code	21201	109	J. Citizen of V US	What Country?	?
	death	nera	11. Maritel Status	12. Was Decedent	Ever in U,S	3.   13. <b>V</b>	Vas Decedent of I-	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Rac	ce - American i	
020	filed within 72 hours after death with the Marylend Hygiene. ther than "natural", or fleme 23a or 28e-f show ent, the Medical Examiner must be notified at	by Funeral	Never Married 2 Merried  3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 元[] If Yes, Give Year or Dates:	No		Yes, specify Cuba	san, Mexican, Puerto Specify:	Rican, etc.)	Specify	ck, White, etc. <sup>y:</sup> whit	
5-0	72 hc	eted	15. Decedent's Ed (Specify only highest gre	ducetion ade completed)		16a. Deced	ent's Usual Occup	pation during most of work ed)	ing 16	b. Kind of Br	usiness/Indust	try
121215-0020	be filed within stal Hygiene. Ind other than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	_	he1per		Но		ternati	ional
$\subseteq$	a la e	0	17. Father's Name (First, Middle, Last) Cornelius Joseph S						e (First, Middle, Ma Virginia		,	
	alth el 27 Is r trau		19a. Informant's Neme/Relationship ( John R. Scanne11	Type, Print) Brothe:	r			ng Boulev			State, Zip Coo VA 201	
Baltimore,	bages ent of nt: If It		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cer	metery, crem	sition (Name of natory or other place —Washing				city or Town, 1, Mary	
Balt	permit. F Departm Importar any Injur		21. Signature of Funeral Service/Licer	MADO LE		- B 3	Name and Addre urgee-He: 631 Fa11:	ess of Facility nss-Seitz s Road	Funeral Baltimore	Home,	Inc. 21211	
1	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	d the death.	. Do not ente	r the mode of dyin	ng, such as cardiac o	or respiratory arrest	,	Ap	oproximate terval Between nset and Death
*	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Acced		terl as a consequ	C(a)	edh	ead 7	ry nr	7 3:	month,
	P is	iner		h							1	
60,	ficate be executed g physician end es the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury	c	Due to (or a	as a consequ	ience of):	- 4	EMMINE	J.I		
x 68760,	E 00 6	Medical	that initieted events resulting in death) Last	O BY MEDICAL O								
Вох	eath certil ettending 1 for use e	clan		d				PICATION APPROVED P	1		Î	
P.O.	the de zy the ached	Physician/M	Part II. Other significant conditions of	-		-		ren in Part t.		cco use cor 2□ No	ntribute to the	e cause of death?
S, D	s that gned t	by P	HIV int	ection					ILI Tes	2 LI NO	3[] FIOUR	ly 70 minum
of Vital Records,	law requires that the death cert as been signed by the ettending 2 should be detached for use	Completed	Hepafit	ection is C.	infi	ection			24a. Was an a performed		availab	autopsy findings ble prior to etion of cause th?
<u>~</u>	0 - 5	E							1 ☐ Yes	212No	1 □ <b>Y</b> €	es 2 No
/ita	ysician: The is certificete director, pag	Be	25. Was case referred to medical examiner?	11					h (Check only one)			
5	\$ 00	5	1 ☑-Yes 2 ☐ No 27. Menner of Death	Hospital: 1 Inpatie		P/Outpatient		4 LI Nursing Ho	me 5 Residence			
e o	ding F. After funer	Certification:	1 □ Natural 5 □ Pending 2 ☑ Accident investigation	(Month, De	y Year)	28b. Time of Injury	28c. Injur Wor M 1□	rk? Yes 2 □ No	28d. Describe how i Fell off		- Steol	
Division	Attan or deal octor: by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Plece of Inju	ury - At hom				28f. Location (Street	and Number		
Ö	safe al Dire	Cert	4   Hornicide	BUT	(Specify)				City or Town, S		21241	Ò
	To the Mospital or Attanding Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edicai	29a. Certifier 1 ✓ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best on niner: On the basis of and manner sta	f examinatio	ledge, death on and/or inve	occurred et the tin estigation, in my of	ne, date and place, a pinion, death occurr	and due to the caused at the time, date	e(s) and ma and place, a	nner as steted and due to the	d. • cause(s)
	To the Control		29b. Signature and title of certifier	4 / )			29c. License				d (Month, Day,	
	· X		· cprebta				D3	4974	10	My 7	20	204
	Α,		30. Name and address of person who of CHAR 4 MEHTA	mp 601			rint)	reet, Bal	timore, 1	4D2	1230	
	Stat Registra	e ar	31. Date filed (Month, Day, Year)	32. Pegistra	ar's Signatu	B	Sparks	/				

	4	Registrer  1. Decedent's Name (First, Middle, Last)			tificate of L	Jeani	2. Date of D	Reg. No	x 111 13	3. Time of Dea	
Physici			SIMPSON				JULY		004 Year	7:00 P	
/Medio		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of De									
- Adii	101	1228 KITMORE RD BALTIMORE CITY									
Funeral		5. Social Security Number 6. Sex 220-08-7374	7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	irth ay, Year,	9. Bir	thplace (State or Fo	
Director		220-08-7374 X-XM  Usual Residence of Decedent	<sup>2□ F</sup> 23	Yrs.			SEPT.			MD	
land ow		10a. State 10b. County	10c. City, To	wn or Loc	ation					10d. Inside City Li	
the Marylar 28a-f show	tor	MD NA	BA	ALTI	MORE					1 XYes 2	
th the	Director	10e. Street and Number			10f. Zip Code	-		10g. Ci	tizen of What C	ountry?	
be filed within 72 hours after death with the Maryland lat Hygiene. Ital Hygiene do ther then "naturel", or Items 23s. or 28s-f show do other then "naturel", or Items 23s. or 28s-f show event. It who deal Examine in all the indifficial at		1228 KITMORE ROAL			212		USA				
er de	Funerai	A	Vas Decedent Ever in U.S. Armed Forces?	If Yes, specify Cuban, Mexican, Puerto R					14. Race - Ame Black, Whi	ican Indian, , etc.	
irs aft	by F		☐Yes 2 <b>X</b> No Yes, Give Year or Dates:	1	☐ Yes <b>ৄ\\</b> Vo	Specify:			Specify: B	LACK	
72 hours "naturel",	ted	15. Decedent's Educatio		a. Decede	ent's Usual Occupa	tion		16b. K	(ind of Business	/Industry	
d within 72 ho giene. er then "natur	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)									
ed wi		9th	NA	DIS	ABLED			<u> </u>			
td be fill lental H ked ott ic even	To Be	17. Father's Name (First, Middle, Last)  LORENZO L. SIMPSON  18. Mother's Name (First, Middle, Maiden Sumame)  MARGO MILLER							Sumame)		
permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiens in Importent: If item 27 le marked other than "naturel; or any injury or other treumatic event. It is Mountal Examinance.		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Name/Relationship (Type, Print)								Zip Code)	
1 and Health tem 27		20a. Method of Disposition	20b. Place	of Dispos	ition (Name of	1	Date		ocation - City or		
Pages nent of I ont: If it		1 ☐ Burial ②☐Cremation 3 ☐Remo 3 ☐ Cremation 3 ☐ Other (Specify)	val from State  METRO		atory or other place EMATORY	.	/6/04	BAI	TIMORE	E. MD	
permit. Pages 1 ar Department of Hea Importent: If item any injury or othe once.		21. Signatur of Funeral Service Licensee	cd/					T. INC.			
88288		- Duyon	1. Teke	4.	300_WABAS	H AVE.	BALTO.	MD	21215		
		23a. Part Lenter the disease, or complication shock, or heart failure. List only one ca	ns that caused the death. Do use on each line.	not ente	r the mode of dying	, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Deatl	
Physician		Immediate Cause (Final disease or condition resulting in death)	MULTIPLE GU		COT W	OUNOS					
/Medical Examiner			Due to (or as a consequence	B of):							
	ē	Sequentially list conditions, b. — b. —	Due to for as a sonsequence	e of):							
uted d ansit	Examine	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
rate be executed only sician and the burial-transit		resulting in death) Last	Due to (or as a consequence	e of):							
cate be ex obysician a the burial	dical	d									
ertifica ling pl	0	IF FEMALE:		- 10.70							
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	yes, outcome of pregnancy  Live birth 2 Fetal deat		Ectopic pregnancy				23d. Date of del Month	livery Day Year	
at the de by the a	ysic		□ Pregnant at time of death □ Unknown	5 🗔 (	Other (specify)						
sicien: The law requires that the descriptions are signed by the rector, page 2 should be detached	y Ph	Part II. Other significant conditions contribu	ting to death but not resulting	in the und	derlying cause give	n in Part I.	23e. Did 1	use contribute to	the cause of death		
quires n sign	ed by						1 🗆	Yes 2	ZNo 3□Pr	obably 4 Unkno	
aw requirass been si	Completed						24a. Was		24b. Were au	utopsy findings availa	
The lavate has	mo						auto perfo	ormed?	death?	completion of cause 2 No	
sicien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Deat					
Physic r this ce	2	1 X Yes 2 □ No Hospit	1 Inpatient 2 ER/O		3 DOA Other	4 La Marsing File			ther (Spe	cify) SCENE	
the aftern	inol in	1 Natural 5 Pending	a. Date of Injury (Month, Day Year)	Time of Injury	28c. Injury Work	?	28d. Describe		-	LACT.	
ttend death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	11104	150		es 2,⊠No			TO WAS JUST  treet and Number or Rural Route Number,		
or Attending after death. Director: Atte	Certification:	4 Homicide determined 28	le. Place of Injury - At home, f building, etc. (Specify)	arm, stree	at, ractory, office		City or To	wn, State	)	PALTIMORE,	
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 ☐ Certifying Physician (Check only 2 ☑ Medicel Exeminer: 6	RESIDENCE  To the best of my knowledge  On the basis of examination a	ge, death	occurred at the time	e, date and place,	and due to the	cause(s)	and manner as	stated.	
the H hin 24 the Fi	Medical	one)	and manner stated.				.cu at the time,				
or To No		29b. Signature and title of certifier			29c. License	number ME			te signed <i>(Monti</i> Z 2, 200	**	
10		20 Marie Land	tod onuse of death (to a co. )	OT		. 11 1)		ТПОС	. 2, 200	· T	
<b>Y</b> )		30. Name and address of person who comple A A A A A A A A A A A A A A A A A A A	ted cause of death (Item 23a) JB10, HD	(Type, P		nn Stree	et, Balt	imor	e, Mary	land 2120	
0	, ,										

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY 4, **Physician** 6:45 P SCHOEN 2004 **JENNETTE** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUNRISE OF PIKESVILLE PIKESVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth MAR. 23, 1913 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🕅 F 91 Yrs. MD 384-26-3580 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumatic event. If a Medical Examiner must be reutified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director pikesville baltimore md 10g. Citizen of What Country? 10e. Street and Number U.S.A. 3800 OLD COURT ROAD #220 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: Be Completed by 3 

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ PRINCIPAL EDUCATION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ROSENBERG FANNIE CAPLAN WILLIAM 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HAROLD ROSENBERG / NEPHEW 30525 RAMBLEWOOD CLUB - FARMINGTON HILLS, MI 48331 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON CHIZUK AMUNO 7/6/2004 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LYMPAOMA disease or condition resulting in death) /Medical Examiner Sequentially list conditions, imm, incause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit ONTONONIA that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4☐Pregnant al time of death 5 Other (specify) 1 ☐ Yes 2 🗹 No the 9 Unknown 9 TUnknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 2 No 1 Yes 201 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Dther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Certification: or Attanding 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No hours after death. 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours at To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifie) 29c. License number 29d. Date signed (Mopth, Day, Year) D-2048L 4-0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 6 1000 5 MOO . 5760 Am DA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 8 2004 Registrar

		•	For State Registrar		State o	f Marylar		artment of I				giene	4 21392
	Physici	an	1. Decedent's Name (First, Mic	die, Lasi GLEN		SCOTT	1				Date of Dea Month	Day 2	3. Time of Death
	/Medic		4a. Facility Name (If not institut				<u> </u>	4b. City, Town, o	or Location	of Death	MY	4c. County of	
	LAGIIII		North Aro	1.de	1 Hos	pital		61en					Arundel
	Funeral		5. Social Security Number 228-07-5000	6. Se	x QM 2□F	7. Age (In yrs. 87	last birthday Yrs.	Months Days	If Under Hours		Date of Birth (Month, Day	, Year) 21 1917	Birthplace (State or Foreign Country)     Vinceinia
	Director		Usual Residence of Decedent								April	21 191/	Virginia
	arylan show	7	10a. State 10b. Cour		- 1 - 1 C		ty, Town or L	ocation adena					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	ecto	Md. Anne	Arui	ndel Co	) •	ras	10f. Zip Code				10g. Citizen of Wh	
	h with	Funeral Director	7777 Tick Ne	ck R	oad			2112	22			U.S.A	
	tama tama	uner	11. Marital Status		Armed Fo		J.S. 13.	Was Decedent of I If Yes, specify Cub	lispanic Ori an, Mexicar	igin? (Specify n, Puerto Ric	y Yes or No- an, etc.)	14. Race - Black,	American Indian, White, etc.
36	irs afte	by F	1 ☐ Never Married 2 💢 M 3 ☐ Widowed 4 ☐ Divorc		1 [X]Yes If Yes, Gi Year or D	Ve		1 ☐ Yes 2 ☒No	Specify:			Specify:	white
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9	filled Hygi other ent.	a	17. Father's Name (First, Midd	e, Last)			<u> </u>					Maiden Sumame)	
Maryland	should be nd Mental marked o	To B	James Em	mitt		Scot	t		Mag	ggie	Kac ———	:hel S	nider
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ē,	f Healt tam 2 othar		20a. Method of Disposition			20b. i		osition (Name of omatory or other pla		Date	_	20c. Location - Ci	
mo	Pages nent of nnt: if		1 🏻 Burial 2 □ Crematic `4 □ Donation 5 □ Other					. Veterans		.07/0	7/04	Crownsvi	11e, Md.
Baltimore,	permit. Departrimports Imports any inju		21. Signature of Funeral Servi	e Licens	70	/	11 /2	2. Name and Addre	ss of Facili y Po	y nigk	Funer	al Home	P.A. Md. 21122
	70 F 8 0		23a. Bart1. Enter the disease, shock, or heart failure. L	or comp	JOM lications that	caused the dea	th. Do not er	3204 I	Mounta	ain Ko	ad, Pa	isadena,	Approximate
E	Physician		Immediate Cause (Final	ist only o	ne cause on	each line.	INCAIN	lav Ac	(1)	tur			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)			(or as a const		Intarc					
	Examiner	10	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		b. Due to	(or as a consec		Lutave	1 000	\			
Т	uted d ansit	Examlne	cause. Enter Underlying Cause (Disease or injury that initiated events	≺		(5, 45 4 55.155	,00.100 0.7.						
Ö,	ate be executed hysician and the burial-transit		resulting in death) Last		Due to	(or as a consec	quence of):		`				
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Ö.		sicla	in the past 12 months? 1 □ Yes 2 □ No								Month	n Day Year	
P.O.	ac ac		9 ☐ Unknown  Part II. Other significant cond	itions co			sulting in the	underlying cause giv	en in Part l		23e. Did to	bacco use contrib	ute to the cause of death?
Records,		d by	Renal	Ins	7/1	cienc	У				1 □ Y	es 2 No 3	☐ Probably 4 ☐ Unknown
COL	law requires as been sign 2 should be	Completed									24a. Was a	an 24b. We	ere autopsy findings available or to completion of cause of
	The te h	Com									perfor	med?// dea	ath? ]Yes 2☑No
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to med examiner?		Hospital: , ,	/	I EDVO	Ott			Check only or		(0/)
10	nding Physician: th. : After this certifica s funeral director, p	n; To	1 ☐ Yes 2 ② No 27. Mann of Death	- 22		Inpatient 2 of Injury eth, Day Year)	28b. Time Injury	INT 3 DOM	4 🗆 190			ence 6 Other ow injury occurred	
sion	Attending in death. ector: After by the fune	atlo	2 LI Accident	stigation	(MO)	ui, Day 1 oai)	injury		Yes 2				
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	To To To To To To To To To To To To To T	Σ	29b. Signature and title of cert	fier	11)	iles	MI	29c. Licens		5	1	29d. Date signed (	
7	141		30 Name and address of pers	on who ro	ompleted cau	se of death (Ite	m 23a) (T <u>y</u> pe	. Print)	1 1	<u> </u>	(1)	July 3, - Buon	100 3.00
	61		30 Name and address of pers					7	al 1	)VIV2	, (5(ex	- Sum	2, 206
	Sta Regist		31. Date filed (Month, Day, Ye JUL 0 8 2		52.1	Registrar's Sign	ature	sporks!					

		AMENIA TYPEN #10D DED	State of Maryla					giene Reg. No 2	Ω I.	21	202
	Dhysisian	AMEND TTEM #10B PER 1. Decedent's Name (First, Middle, Last,	FH G833 7/08	2. Dete of De		Yeer	3. Time	of Death			
-	Physician /Medical	MAX	atmat and sumbar	SCH	WARTZ	h City Town or	Tury 03 2004 2: 40 Por Location of Deeth 4c. County of Death				
į	Examiner	4e Fecility Neme (If not institution, give FUTURE CARE CHES			7	ARNOLD	LOCATION OF DEGIN	ANNE AF			
	Funeral Director	5. Social Security Number 6. Sec		Mon	nder 1 Year ths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da AUG. 9, 1			ace (State	e o <i>r Foreign</i>
	pue & #	Usuet Residence of Decedent  10a. Stete 10b. County	10c. C	ity, Town or Location					10	Od. Inside	City Limits
	Mary and about	NY NEW		BR00KL'	YN					1 □ Y6	es 2□No
	with the Man or 28s-fa	10e. Street end Number	THUE #ED	10f	. Zip Code	11010		10g. Citizen of \	Whet Count	ry?	
	r teme 23 other must	2525 NOSTRAND AVI	12. Was Decedent Ever in U		ecedent of His	11210 spanic Origin? (S	pecify Yes or No		e - America		
215-0020	by by	3 Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		specify Cubar es 2 🕅 No	n, Mexican, Puèrt Specity:	o Rican, etc.)	Specify	ck, White, e	etc. WHIT	Έ
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Maryland			mo Print)	SCHWAR		BRINA		IERRILL		ENOF	SKY
	nd 2 :	1.1.5	DAUGHTER				ARNOLD.			5006)	
Baltimore,	S 4 2 2	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X	temoval from State	Place of Disposition cemetery, crematory	or other place		Date	20c. Location -	City or Tov	vn, State	
Him	2 7 8 9	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	∫ KN	OLLWOOD PA	ARK e end Addres:		7/6/04	RIDGE			
Ba	permit. Bepertmin importar any injure.	21. Signature of Funeral Service Licensis	7 -				OL LEVIN ROAD -				
		23a. Pert1. Enter the disease, or complishock, or heart faiture. List only or	cations that caused the dee							Approxim Interval B	nate
7	Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)		AMON!						Onset and	d Death
V	executed in end itelatrinsit	b									
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68760,	di the	that initieted events	Due to (	or es e consequence	of):						
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	at the death certion of the attending at ached for use a Physiciar/M	Part II. Other significant conditions con	tributing to death but not re-	sulting in the underlying	ng cause give	n in Part I.	23b. Did t	obacco use cor	ntribute to	the caue	e of death?
P.0	that tha de ed by the a datached		n DIFFIC	ILE C	OLIT	1.5	101	res 2□ No	3 Prob	ably 4	Mknown
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eco	The law requir sate has been single 2 should Completed						perior	med:	com	pletion of eath?	
al B	certificate harector, pege						1 U Y		10	Yes 2	□ No
Z.	Physician: this certificated director,		lospital: 1   Inpatient 2	ER/Outpatient 3	DOA Othe	7.	th <i>(Check only o</i> o ome 5□ Resid		er (Specify)	)	_
n of	ding Phy h. After thi funeral		28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury Work	at ?		ow injury occurr			
Division	Attending or death. ector: After by the fune iffication	2 Accident investigetion 3 Suicide 6 Could not be	28e. Place of Injury - At h	M nome farm street fac		es 2 □ No	28f. Location /S	treet and Numb	er or Rural	Route No.	ımber
<u>≥</u>	tal or Attending P rs after death. In Director: After t led in by tha funere Certification:	4 ☐ Homicide determined	building, etc. (Speci		,,		City or Tow				
	he Hospit in 24 hour he Funera pletely filli edical (	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examir	sician: To the best of my known or: On the besis of examina	owledge, death occur ation end/or investiga	red at the time tion, in my opi	e, date end place inion, death occu	and due to the c	ause(s) and ma	nner as sta	ited. the cause	e(s)
	To the Hospital or I within 24 hours after To the Funeral Dire completely filled in EMEDICAL MEDICAL CERT	29b. Signature end title of certifier	and menner stated.		29c. License	number	2	29d. Date signed	(Month, D	lay, Year)	1
	- >- 0	1 mongs	m		D5	7531		July	04,	2001	4
	NY	30. Name end eddress of person who co	,								
	State	Mohir Nes 860 31. Dete filed (Month, Way, Yeer)	32 Registrer's Sign	eture /	rillar	sville	mo	21108			
	Registrar	JUL 0 8 2004	Dreva	D 40	als						

	1	1 - State AMEND ITEM #	State of Mar 10B&26 PER	yland / Dep PEY G8 <b>3</b> 8	artment of H 1708/04 rtificate of i	lealth and N Death		giene Reg. No. 2	ni.	2120
		Decedent's Name (First, Middle, Las					2. Date of Dea	ath Day	Year	3. Time of Death
Physic /Medi				one	Ab City Town o	r Location of Death	JULY	06 2	y of Deeth	6: 45PM
Funeral Director	ner	4a. Fecility Name (If not institution, gives 1411 Rainbow II 5. Social Security Number 6. Security Number 214-40-0532	rive 7. Age	In yrs. last birthda;		a dena If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Oct. 12	Anne h y, Year)	e Arı	place (State or Foreigntry)
PL ,		Usual Residence of Decedent  10a. State 10b. County	1,	IOc. City, Town or	Location					0d. Inside City Limit
arylar show	ō	10a. State 10b. County  Maryland Anne Aru:	1	Pasadena						1 ☐ Yes 2 💆 N
28a-f	Directo	10e. Street and Number	idei	- abadena	10f. Zip Code			10g. Citizen of	What Cour	ntry?
3a of	0	141 <del>1 Rainbow Drive</del>	_ 1247 CAS	TINE COUR	TS	21122		US	A	
be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Mcdrcal Examinar start be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		B. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗵 No	lispanic Origin? (Sj an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Bla	ce-Americack, White,	etc.
72 ho	Completed	15. Decedent's Ed (Specify only highest gra		(Giv	edent's Usual Occup ve kind of work done	during most of wor	king	16b. Kind of 8	Business/In	dustry
within lene. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	) life	. DO NOT use retired Engineer	•		Northr	op Gr	umman
filed v Hygie other i		12 17. Father's Name (First, Middle, Last)	0			18. Mother's Nam	ne (First, Middle,			
outd be Mental arked o	To Be	Stanley Roze	k			Edith		Berr	y	
s 1 and 2 should be filed within 72 hours aft Health and Mental Hygiene. Item 27 is marked other than "natural", or other traumatic event, Ina Medical Exami	-	19a. Informant's Name/Relationship (7	ype, Print)		iling Address (Street					
1 and 2 Health a em 27 la		George W. Stone J	r. (son)		Rainbow	Drive, Pa				
0 = 0		20a. Method of Disposition  1 ☐ Burial 2 🏋 Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Specify		cemetery, cr	position (Name of rematory or other place Crematory	7-8-	-O4	20c. Location Baltimo	•	aryland
permit. Pag Department Important: sny injury once.		21. Signature of Funeral Service Licen	S00	/ / M	22. Name and Addre	lyniak Fu	neral H	ome P.A	. 1 1	21122
40200	-	23a Jart1. Enter the disease, or com	plications that caused the		204 Mount				yland	Approximate Interval Between
Physician /Medical Examiner	Examiner	Infimediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, that y leading to thread to cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of:	IA OF	LUNG	<i>5</i>			
h certificate be executed ending physician and use as the burial-transit	edicai	IF FEMALE: 23b. Was decedent pregnant	Due to (or as a d		3 □Ectopic pregnanc	,			ate of deliv	*
that the death certifued by the attending I	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at ti 9☐ Unknown		Other (specify)			M	lonth	Day Year
The law requires that the death certifution has been signed by the attending lage 2 should be detached for use as	b	Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause giv	ren in Part I.	į	Yes 2□No	3 🗀 Prot	he cause of death?
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Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		ont 30 DOA Off	26. Place of Dea	_			SON"S
S 50	.To	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient	28b. Time	IN JUDON	4   Huising I	ome 3 Resident	12.12		y RESIDENC
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a 를 를 드	Certification:	4 Homicide determined	building, etc.	street, factory, office	City or			ttion (Street and Number or Rural Route Number, or Town, State)		
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	ysician: To the best of niner: On the basis of e and manner state	examination and/or	ath occurred at the til investigation, in my o	me, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and n date and place	nanner as s , and due t	tated. o the cause(s)
To th within To th	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)
18		30. Name and address of person who	m D	ath (Item 23a) (Tyn		57531		July	¢7,	2004
1,		mohit region				Merci	le, m	0 2110	8	
S Regis	tate trar	31. Date filed (Month, Day, Hear)  JUL 0 8 200	32. Registrar	's Signature	Sports					
OHMH 17 Rev 1		335 0 9 200	4 Coner	B	sports	/				

DHMH 17 Rev 1/2001

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and Mo	ental Hygi	ene	_
		_1	- State Certificate of Death	Re	g. No. U U	21395
Phys	sicia	_	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Yeer	3. Time of Death
	edica	II.	ELIZABETH TURNER	144	2 200	
Exa	mine	r '	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. City, Town, or Location of Death  4c. City, Town, or Location of Death  4c. City, Town, or Location of Death  4c. City, Town, or Location of Death  4c. City, Town, or Location of Death		4c. County of Dea	TRUNDEL
<b>-</b>			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Bir	hplace (State or Foreign
Funer Direct		-	220.68.1175 1 M 2 F 46 Yrs. Months Days Hours Min.	Month, Day,	Year) Co	HAND
ס		<b>}</b> −	Usual Residence of Decedent	-	1 2	
anylar show		. 1	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
he M		-	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	
with t		5	204 RAPPARA CT			A.
death with the Maryland ms 23a or 28a-f show		runeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Status 13. Was Decedent of Hispanic Origin? (Specific Status 14. Was Decedent of Hispanic Origin? (Specific Status 15. Was Decedent of Hispanic Origin? (Specific Status 15. Was Decedent of Hispanic Origin? (Specific Status 15. Was Decedent of Hispanic Origin? (Specific Status 15. Was Decedent of Hispanic Origin? (Specific Status 15. Was Decedent of Hispanic Origin? (Specific Status 15. Was Decedent of Hispanic Origin? (Specific Status 15. Was Decedent of Hispanic Origin? (Specific Status 15. Was Decedent of Hispanic Origin? (Specific Status 15. Was Decedent of Hispanic Origin? (Specific Status 15. Was Decedent of Hispanic Origin? (Specific Status 15. Was Decedent of Hispanic Origin? (Specific Status 15. Was Decedent of Hispanic Origin? (Specific Status 15. Was Decedent of Hispanic Origin? (Specific Status 15. Was Decedent Origin? (Specific Status	cify Yes or No-	14. Race - Ame	
after or ite	L	2	Armed Forces? If Yes, specify Cuban, Mexican, Puerto F  1 Never Married 2 Married If Yes, Give 1 Yes, Specify:	Hican, etc.)	Black, Whit	e, etc.
hours after tural', or ite		S D	3 ☐ Widowed 4 ☑ Divorced Year or Dates:		u	NITE
"natu		Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of workin		6b. Kind of Business	Industry
filed within 72 Hygiene. Sther than "na!		E C	Elementary/Secondary (0-12) College (1-4or 5+)	:   H	FALTH C	ARE
ifiled Hygi	1	e Re	17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, M	laiden Sumame)	
DESILIMOTE, INIGITY ISTICA Z. 12-0050  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment may be notified as		<u>0</u>	EVERET TURNER MARY	STAM	FORD	
Z should and Men is marke			19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Pural	Route Number,	City or Town, State,	Zip Code)
and and mark		5	STEPHANIE A. TWIGG, DAUGHTER 5 MARLEY NECK RO. CI		SEMD 2	
Pages 1 nent of H nnt: if Itel			1   Burial 2   Stamation 3   Removal from State   Comptery, crematory or other place)	ate 2	Oc. Location - City or	
mit. Pages partment of portant: If It		1	4 Doogtion 5 Other (Specify)  21. Signature 1 of all Service Licenses  22. Name and Address of Facility	5,2004 B	ATIMORE,	MD.
Dall permit. Departi Import	Buce		21. Signarive 1 Feral Service License 22. Name and Address of Facility  Daugherty Family Funeral Hot	me And Crema	ition Center, P.A.	
		+	23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	Pasadena, M r respiratory arre	D. 21122 st,	Approximate
Dhysisi	an .					Interval Between Onset and Death
Physicia /Medic			Immediate Cause (Final disease or condition resulting in death)  a. AHOYIC FACE-PHALOPATHY  Bue to (or as a consequence of):			
Examin	er		TATUS PRILLIS			
D =		ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying			
ecuter and trans		Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
7X OCT OU, Certificate be executed Ading physician and	!		Due to (or as a consequence of):			
cate cate		dicai	d			
h certif		√Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	ivery
COLOS, T.O. BOX of requires that the death certific been signed by the attending is should be detached for use as		Physician/M	in the past 12 months?  1   Ves   2   Ves   3   Ves   5   Other (specify)		Month	Day Year
by the C		,nys	9 ☐ Unknown 9 ☐ Unknown		-	
ords, F.C. requires that the een signed by th hould be detache		2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	
ecords, law requires t as been signe		ted		1 L Yes	s 2 □ No 3 □ P	obably 4 Monknown
4 6 S C		Completed		24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
ate T				1 ☐ Yes 2	Yes 1 ☐ Yes	2 12 No
Of Vital F Physician: Th this certificate ral director, pac		o Be	25. Was case referred to medical examiner?  Hospital:   Mospital:			
OT Phys or this		-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	ne 5 Hesider 28d. Describe hov	nce 6 Other (Spe w injury occurred	city)
VISION Attending r death. ctor: After		atlor	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
DIVISION  I or Attending after death.  Director: After in by the fune		Certification:	a Classic Could not be	28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
Salar Salar C		Cer	Tallang, on Topology			
DIVISION OF  To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Affer th completely filled in by the funeral		edical	29a. Certifier (Check only)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred medical Examiner:			
thin 24		Med	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Mont	h. Dav. Year)
1 × 1 × 2	3	-	10 D 45149		24 2	2004
\		-	30 Name and address of person who completed cause of death (Item 23a) (Type, Rrint)			
	1		CHAPONO 301 HOSPITUL Drive CLEN	s Burr	ve mit	2061
	Stat	-	31. Date filed (Month, Day) Year) 32. Registrar's Signature			X-= 1 - 1 - 1 - 1
Reg	jistra	ır	JUL 0 8 2004 And & marks			

04-03938 Michael Thomas RJD

)			1 - State Amend Items Registrar		l6a, ben Ceri	rtment of F 7, 18, 19a tificate of	lealth and Death	Mental Hy	7/08/04 Reg. No.	hb	21396	
Phy	sicia	ın	1. Decedent's Name (First, Middle, L	•				2. Date of De Month	Day	Year	3. Time of Death	
<b>)</b>	edic		Michael Thomas. Facility Name (If not institution, gr			4h City Town o	r Location of Dea	June 1		- 12 "	2058P. <sup>™</sup>	
EX	ımin	er	Laurel Regional			Laurel	Location or Dea	Death 4c. County of Death Prince Geo			orgoe	
Fune Direc	_	٥.	5. Social Security Numbeunk 6. 135–44–1655	-	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr	s. 8. Date of Bir (Month, Date of Sept 2	th av. Year)		ace (State or Foreign y)	
P >			Usual Residence of Decedent	140.00								
Maryla -f shov		tor	MD 10b. County Anne A	runde1	ty, Town or Loc Je			10d. Inside City 1 ☐ Yes				
th the		Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Countr	y?	
ath wi	National Property of the Prope	ral	P.O. Box 549				20794			USA		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or teems 23s or 28a-f show		by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🖪 No 1 If Yes, Give	unk	as Decedent of H Yes, specify Cuba □ Yes 2🎇 No	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		e - America ck, White, et blac	c.	
2 hour	4	ted t	15. Decedent's B	Year or Dates:	16a. Decede	ent's Usual Occup	ation	unk	16b. Kind of Bu			
21215-0036 d within 72 hours aff gjene. ar than "natural", or		Completed	(Specify only highest gi	College (1-4or 5+)	(Give k	ind of work done of O NOT use retired	during most of wo	orking			dire	
d 2 filled Hygie			17. Father's Name (First, Middle, Las		riaciiii	ne operat		me (First, Middle,		binde		
rlan utd be Mental		To Be	Clarence The	onas				Leather		, 	<del>unk</del>	
Maryland 4 2 should be file th and Mental Hy		•	19a. Informant's Name/Relationship  Dr. Terra Thomas		111	Jann Ctm	00+ Dol+	ural Route Numbe	D 01001		Code)	
re, s 1 an Heal			20a. Method of Disposition	20b. P	Place of Disposi	tion (Name of		Chreago,	20c. Location -		n, State	
altimore, mit. Pages 1 ar partment of Hea			1 Burial 2 Cremation 3 [ '4 Donation 5 MOther (Special	fy) in state		atory or other place						
Balti permit. Departin Imports	ouce		21. Signature of Funeral Service Lice RODA LO	Mall	Ва	ltimore.	MD 212	d 655 W. 01		ore St	reet	
	3: 10		Baltimore, MD 21201  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, by heart failure. List only one cause on each line.  Atherosclerotic Cardiovascular Disease									
Physici /Medi			Immediate Cause (Final disease or condition resulting in death)	a. Coronary Ar	tery Th	rombosis	-	DICCE			Onset and Death	
Examin			1	Due to (or as a consequ	uence of):							
$\mathbb{N} = \cdot$		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	uence of):							
acuted		amin	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						1	
68760, lificate be executed g physician and			resulting in death) Last	Due to (or as a consequ	uence of):							
68760, ifficate be ex g physician a		edical		d								
Box 68760, eath certificate be executed attending physician and			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date	e of delivery		
Records, P.O. Box The law requires that the death cert the has been signed by the attendin		Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Other (specify)			Mon		ay Year	
IS, P		by Pr	Part II. Other significant conditions	contributing to death but not resu	ulting in the und	lerlying cause give	en in Part I.	23e. Did to	obacco use contri	ibute to the	cause of death?	
cords w require		ed						1 🗆 Y	res 2□No	3 □ Probab	ly 4 □Unknown	
Records, he law requires to the law been signed and 2 should he as a should he are 2 should he are 2 should he are 3 should he		Completed						24a. Was	an 24b. W	Vere autopsy	y findings available letion of cause of	
	2							perfor	rmed?	eaun?	□ No	
of Vital F Physician: Th rhis certificate		20	25. Was case referred to medical examiner?	Hospital:		2□ DOA Othe		ath (Check only o				
Phy Phy		0	1X Yes 2 □ No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA 28c. Injury	4   Nursing r	dome 5 ☐ Resid	lence 6 Othe			
Z = Z		atlo	1  Natural 5  Pending 2  Accident investigation	(Month, Day Year) n	Injury	Work	k? Yes 2 □ No		,,			
Division of Attanding after death. Diractor: After		Certification;	3 Suicide 6 Could not be determined		ome, farm, stree	t, factory, office		28f. Location (S City or Tow	Street and Numbe m, State)	r or Rural R	oute Number,	
ppital cours a			29a. Certifier 1□ Certifying Pl	nysicien: To the best of my know	Wledge death s	accurred at the time	o data and place	and due to the				
DIVI To the Hospital or At within 24 hours after or To the Funeral Direct commission files		edical	(Check only one) Medicel Example (Check only one)	niner: On the basis of examinat and manner stated.	tion and/or inve	stigation, in my op	pinion, death occu	rred at the time, o	date and place, a	nd due to th	e cause(s)	
To tha within 2 To tha			29b. Signature and title of certifier	1 00	)	29c. License		- 4	29d. Date signed			
			Lahin	Mah AS		O.C.M	1.E.		June 1	5, 200	J4	
		j	30. Name and address of person who	AH ALI		111 5		eet, Bali	timore,	Maryl	and 21201	
Reg	Stat istra	٠.	31. Date filed (Month, Day, Year)	6 2004	ture &	fred ?	1:	70				

DHMH 17 Rev 1/2001

	State of Maryland / Department of Health and Mental Hygiene  1- State Registrar Certificate of Death Reg. No. 1 1 2 2 3 7										
	Physici		Decedent's Name (First, Middle,		Mae Vajo			2. Date of Deat Month		3. Time of Death 7:20 а.т. м	
}-	/Medic Examin		4a. Facility Name (If not institution,	give street and number 6312 Bright P		4b. City, Town, or L		umbia	4c. County of Dea	ath Howard	
	Funeral Director		5. Social Security Number 151.36.6472	6. Sex 1 □ M 2 F 7. A	ge (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, November		rthplace (State or Foreign country) New Jersev	
	ryland ihow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
	h the Ma or 28a-1 s	Director	Maryland  10e. Street and Number	Howard		10f. Zip Code	olumbia	1	0g. Citizen of What C	•	
	ter death wil Items 23a c	Funeral D	6312 Bright Plume	12. Was Deceden	t Ever in U.S. 13.	Was Decedent of His	21044 panic Origin? (Sp	ecify Yes or No-	14. Race - Am		
920	72 hours after death with the Maryland natural', or tlems 23a or 28a-f show Jical Exantral the notilled at		1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces ad 1 Tes 25 If Yes, Give Year or Dates	No	If Yes, specify Cuban	Specify:	rican, etc.)	Black, Wh	White	
21215-0036	within ene. than	Completed by	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 12		(Give	dent's Usual Occupat kind of work done du DD NOT use retired) Administra	ion wring most of work ative Assista	ing	16b. Kind of Business College Co	s/Industry unseling Center	
Maryland 2	should be filed and Mental Hygle s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, L Max	ast) G. Kaufmann			18. Mother's Nam		Maiden Sumame) nary E. Windel	l	
Mary	d2: th ar 7 is trac		19a. Informant's Name/Relationsh Mr. Victor S. Vaji		nd Number or Run me Columb		, City or Town, State, 21044	Zip Code)			
Baltimore,	0 0		20a. Method of Disposition 1 □ Burial 2 ▼Cremation 4 □ Donation 5 □ Other (So		)	Date :	20c. Location - City o	r Town, State e, Maryland			
Baltii	permit. Pag Department Importent: I any injury o		21. Schature of Funeral Service		of Facility Ineral Home	e, P.A. Pike Ellicott	City, MD 2104	3			
	Priysician	30	23a. Part 1. Enter the disease, of the shock, or heart failure. List of Immediate Cause (Final disease or condition	or respiratory arre	est,	Approximate Interval Between Onset and Death					
	/Medical Examiner		resulting in death)	Due () (or a	s a consequence of):	۵.	Ø			2200	
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate causs. Enter undarying Cause (Disease or injury that initiated events	Due (d) (or a	s a consequence of):					d	
8760,	icate be executed physicien and the burial-transit	dical Ex	resulting in death) Last	Due to (or a	s a consequence of):						
P.O. Box 68	ne death certifi the ettanding thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of de Month	slivery Day Year	
	quires that the signed by all be detacted	þ	Part II. Other significant condition	ns contributing to death	but not resulting in the u	nderlying cause giver	in Part I.	23e. Did tob	<b>—</b>	to the cause of death? Probably 4 □Unknown	
Vital Records,		Completed						24a. Was ar autops perform 1 \sum Yes 2	y prior to ned? death?	utopsy findings available completion of cause of	
f Vita	Physicien: The this certificate hiral director, page	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital: 1  Inpar	me K Reside		ecify)				
Division of	ding After fune		27. Manner of Death  1 Matural 5 Pending investige	ation	jury 28b. Time o lnjury	Work?	at es 2 □ No	28d. Describe ho	ow injury occurred		
Divis	tel or Attenders after deall al Director:	Certification;	3 Suicide 6 Could n 4 Homicide determin	had 288. Place of I	njury - At home, farm, str etc. (Specify)	reet, factory, office		28f. Location (Sti City or Town	reet and Number or F n, State)	lural Route Number,	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical	29a. Certifier (Check only one) Certifying	y Physician: To the bes xaminer: On the basis and manners	t of my knowledge, deat of examination and/or in stated.	vestigation, in my opi	nion, death occur	red at the time, da	ate and place, and du	e to the cause(s)	
)	With Com	Σ	29b. Signature and title of certifier		in	29c. License	number (1 3 9	1	9d. Date signed (Mon	th, Day, Year)	
10	8	_5	Clement Kno	ent mo	death (Item 23a) (Type,	Print) Patur	ent Pku	oy Cou	imaci!	MBIOUY	
	Sta Registi		31. Date filed (Month, Day, Year) - JUL 08 2		trar's Signature	land		•	\		

DHMH 17 Rev 1/2001

ORIGINAL

JNK 04-234 SEAN MICHAEL WI 04-4389	LLI	LIAMS Please			delible lnk. Ensure artment of Health and		_	
MAN	•	= State Registrar		Cei	tificate of Death	Reg	NB. 0 1	21398
Physicia /Medica		1. Decedent's Name (First, Middle, Las	st)	Will	iams	2. Date of Death Month July 05,	Day Year	3. Time of Death 0439 A M
Examine	ar 🗎	4a. Facility Name (If not institution, given 100 Calvert Street at		r Street	4b. City, Town, or Location of Dealtimore	ath	4c. County of Death	
Funeral	-	5. Social Security Number 6. S	Sex 7. Age (Ir	yrs. last birthday)	If Under 1 Year  If Under 24 Hi Months Days Hours Mi		9. Birth	place (State or Foreign
Director		Usual Residence of Decedent	ØM 2□F	A/ Yrs.		Dec Bil	982 OK 1	ahoma
s Marylan	tor	mp NA		Baltimo				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
death with the Maryland ms 23c or 28a-f show figural be tradified at	Funeral Director	10e. Street and Number 2830 EdgeCon	nb Circle	South	10f. Zip Code 2/2/5	109	. Citizen of What Cou	intry?
336 urs after deati	by Funera	11. Marital Status  1 12 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates:	i	Vas Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White Specify: Bl	
Iltimore, Maryland 21215-0036  nit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla ariment of Health and Mental Hygiene.  ortant: If itam 27 is marked other than "natural", or itams 23c or 28a-1 show injury or other traumatic event, the Marical Examination will be marified at 8.	Completed	15. Decedent's Ec (Specify only highest green properties of the control of the co	ducation ade completed)  College (1-4or 5+)	(Give	ent's Usual Occupation kind of work done during most of w O NOT use retired)	orking	b. Kind of Business/Ir Restaurar	•
/land 2 uld be filed Mental Hygi arked other	To Be C	17 Father's Name (First, Middle, Last)	ims		18. Mother's N	ame (First, Middle, Mal	OSTELDEN	,
re, Mar.		19a. Informant's Name/Relationship (Victoria Willia)	ms - mothe	R 293	g Address (Street and Number or)  Edge Comb C	ircle Sour	th Balto. M	0 81815
Baltimore, permit. Pages 1 are Department of Hea Important: If item any injury or othe once.		20a. Method of Disposition  1	Removal from State	20b. Place of Dispo cemetery, crer	inton (Name of paton)  Lemetery 7-9	Date 200	c. Location - City or T	own, State
Balti permit. Departm Importa		21. Signature of Funeral Service / icon	1500	Con Con	Name and Address of Ficility	Fredholko Ka	ss Balton	1 21229
Physician /Medical		23a. Palt File r the disease, or comshock, o heart failure. List only Immediate ause (Final disease condition resulting in death)	plications that caused the one cause on each line.  a	WLTH	or the mode of dying, such as cardi	ac or respiratory arrest.	LON	Approximate Interval Between Onset and Death
Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	onsequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a co	onsequence of):				
ox 68760, certificate be exceptificate be exceptificate by exception and a second seco	edicai		_d					
O Cerr	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	]Fetal death 3 □	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	very Day Year
	þ	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	derlying cause given in Part I.	23e. Did tobac	co use contribute to t	the cause of death?
4 6 8 N	Completed					24a. Was an autopsy performed	d?   death?	opsy findings available ompletion of cause of
Vita	) Be	25. Was case referred to medical examiner?  1X Yes 2 □ No	Hospital:	2 ER/Outpatien	1 4 4	eath (Check only one) Home 5 Residence	a 6 Mother (Sans	At scene
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injury at Work?	29d Describe how		
Divis al or Atte al or Atte s after de it Diracto	Certification:	3 Suicide 6 Could not b 4 Comicide determined		At home, farm, str Specify) L(C)	eet, factory, office	28f. Location (Stree City or Town, S	tand Number or Run State) / 80 BL	al Route Number, UCK CACJEAT BALTIMURS
a Hospit 124 hours 185 Funera	edicai (	29a. Certifier (Check only one)  1 Certifying Pr 2 Medical Exar	nysician: To the best of m niner: On the dusis of exa and marrier stated	amination and/or in	occurred at the time, date and pla estigation, in my opinion, death oc	ce, and due to the caus	e(s) and manner as s	stated.
To th within To th comp	Me	29b. Signature and title o certifier	1 h	0	29c. License number O.C.M.E.	1	Date signed (Month, uly 05, 20	
3		30. Name and address of persop with	completed cause of death	n (Item 23a) (Type,	Print)  1 Penn Street, F	Baltimore, 1	Maryland 2	21201
Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's	1	6			
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State of Maryland / Department of Health and Mental Hygiene For State Registra 1-Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 8700 M **Physician** leber July eun. JR 2004 3 /Medical City, Town, or Location of Death 4a. Facility Name (If hot institution, give street and number) 4c. County of Death **Examiner** JENUR Srook Lyn If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y Oct. 18, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days Hours Months 10XM 2□ F 55 1948 217 46 4999 Maryland Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County 23e or 28e-f show the Medical Examinar must be natified at 1 ☐ Yes 2X No Brooklyn Park Director Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 110 - 2nd Avenue 21225 U.S. filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 Married 5 Specify: White Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced neturel Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Laborer MD. Environmental 12th .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tent: if item 27 is marked other t jury or other traumetic event, IL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred L. Herbert Henry A. Weber, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 110 - 2nd Avenue Baltimore, Maryland 21225 Frances O'Brien / sister Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department o importent: if any injury or once. Glen Haven Mem. Park 7/7/2004 Glen Burnie, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 nomuauen 23a. Pater. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) \_,Pnysician therioscherotic /Medical ue to (or as a consequence of): betes **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): Examiner nonce and Due to (or as a consequence of) burial-P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 \( \text{Yes} \) 2 \( \text{No} \) 3 ☐ Ectopic pregnancy Day Year Month jo 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Division of Vital Records, à 2 No 3 Probably 4 Unknown 1 Yes Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes el or Attending Physicien: T s after death. il Director: After this certificat id in by the funeral director, pa 25. Was case referred to medical examiner?
1 Syes 2 \( \text{No} \) No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 A Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending 1 🗌 Yes 2 🗆 No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide To the Hospitel o within 24 hours aft To the Funerel Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Deputy mo person who completed cause of death (Item 23a) (Type, Print) 95 America 10 NOS 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 88 2004 Registrar

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

M

who completed cause of death (Item 23a) (Type, Print)

JUL 0 8 2004

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

July 04, 2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 2004 July 8:00 A Daniel Wayne Youells, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 3317 A Washington Blvd. Baltimore 8. Date of Birth (Month, Day, Year) Sep. 14, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1**X** M 2□ F 1971 32 Maryland Director 218-84-6987 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County "natural", or Items 23a or 28a-f show utical Examinating at 1 ☐ Yes 2 🔯 No Director Baltimore Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code United States 21227 3317 A Washington Blvd. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Ferric 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry Welder 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Deborah Ann Herr Daniel W. Youells, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3317 A Washington Blvd., Baltimore, MD 21227 Deborah Youells Mother 20b. Place of Disposition (Name of cometery, crematory or other place)
Meadowridge Memorial
Park 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 7-6-2004 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice 1500 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC ESOPHAGEAL CANCER WITH LIVER Pnysician 6 MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a cursequence off. Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): 68760. Physician/Medicai Box ( IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. | the hed 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the within 2 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier 0 07/02 2004 22832 on him, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HKRIOGE, MD 21075 5808 MAIN Street Dr SOON FA Kim 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 8 2004 Registrar

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JD		State of Maryland / Department of Health and 1- State Registrar #14 & Unpend Item #23a 27, 28a-f perfection of Death	Mental Hyg	ene
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/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea	July 04	, 2004 2358P. M
Examili	ıçı	Northwest Regional Hospital Randallstown	200	Baltimore
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr		
Director		578 - 76 - 4125 10/M 2 F 48 Yrs. Months Days Hours Mir	n. G-2"	55 Country Cuba
and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		104 (22)42 (2)4 (3)4
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16 after death w or Items 23E	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cyban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian,
36 s after or It	y Fu	1 Never Married 2 Married 1 Yes 2 M No	arto Ficari, etc.)	Black, White, etc.  Specify: <b>Hispanic</b>
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e filed al Hygi other	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Na	ame (First, Middle, M	laiden Sumane)
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel", or Items 23s or 28s-1 show sumatic event, the Medical Examples in must be notified at	To	Alphonso Wright		
C 4 2 2 2		19a. Inf. mant's Name/Relationship, e, Print)  19b. Mailing Address (Street and Number or F	Rural Route Number,	City or Town, State, Zip Code)
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O 2°= 5		20a. Meylod of Disposition  20b. Place of Disposition (Name of cemetary, cematory or other place)	Date 2	Oc. Location - City or Town, State
Baltimo		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	5 04	KOSVIILE III
Bal permi Depa Impo any ii		21. Signature of Funeral Service Licensee	uynny.	Letinin MN 2122
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failbed. List only one cause on each line.	ac or respiratory arre	st, Approximate
Physician		Immediate Cause (Final Cooping Polated Agitated Polinium		Interval Between Onset and Death
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ic is a	cal E			
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Box 68 eath certific attending p	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
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ires that signed I be de	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Cardionegaly		acco use contribute to the cause of death?
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Recarded the second sec	Idm		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Division of Vital Records, or attending Physicien: The law requires tafter death.  Director: After this certificate has been signe in by the funeral director, page 2 should be come.	e Co	OS III.	perform 1 X Yes 2	ed? death? □ No 1/5 Yes 2 □ No
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g Phy gerthis	-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ce 6 Other (Specify)
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Vision representation of the by the	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 【Could not be determined  28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)		et and August But all Bout Country State) 45 Mer Tam
ital or rs aft	Cer	Residence	Owings M	fills, Maryland
	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the content of the content	e, and due to the cau	ise(s) and manner as stated.
thin 2 the mplet	Med	29b. Signature and title of certifier 29c. License number		
F × 5		Zabrillah Alt O.C.M.E.		d. Date signed (Month, Day, Year) uly 05, 2004
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DHMH 17 Rev 1/2001

Registrar

LIEGLER, KEGINA

			Please 1	ype or Print in Blac	k Indelible Ink. Ensure	All Copies Are	e Legible.
			1 - For State Registrar		Department of Health and Certificate of Death	Mental Hygien	2001 01101
	E		1. Decedent's Name (First, Middle, Last			2. Date of Death	3. Time of Death
	Physic /Medi		HYMAN	ISAAC	ZOLET	as desired	Day Year 7:17 PM
	Exami		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea		Ic. County of Death
	Funeral	М	Sinai Hospital o 5. Social Security Number 6. Se.		Baltimore Ci	8. Date of Birth	N/A
	Director			AM OCIE	Yrs. Months Days Hours Min		9. Birthplace (State or Foreign Country) MD
	and and		10a. State 10b. County	10c. City, Towr	or Location		10d. Inside City Limits
	vith the Marylan or 28a-1 show be notified at	ctor	MD BALTI	MORE R/	ANDALLSTOWN		1 □Yes 2 ☑ No
	death with the Maryland ms 23a or 28a-f show rmist be rodified at	Funeral Director	10e. Street and Number 8421 ALLENSWOOD	ROAD	10f. Zip Code 21133	10g. C	Citizen of What Country?
	deat	ner		12. Was Decedent Ever in U.S. Armed Forces? WWI I	13. Was Decedent of Hispanic Origin? (	Specify Yes or No-	14. Race - American Indian,
5-0036	s 1 and 2 should be filed within 72 hours atter death w If Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a other treumatic event, the Medical Examiner must.	by	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 Myes 2 No COAST 1 Fear or Dates: GUARD	If Yes, specify Cuban, Mexican, Puèi 1 ☐ Yes 2 🛣 No Specify:	to Rican, etc.)	Black, White, etc.  Specify: WHITE
215-(	within 72 hours ene. than "naturel", te Medical Exa	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16a	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	orking 16b.	Kind of Business/Industry
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pu	be fill tal Hy d oth	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, Maide	on Sumame)
<u>y</u> la	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the M.	ို	SAMUEL		OTOWITZ SARAH		CHLOVITZ
Maryland	d 2 sh th and 7 Is m treum		19a. Informant's Name/Relationship (Ty		Mailing Address (Street and Number or R		
	1 and Healt em 2		HULANE S. ZOLET		P21 ALLENSWOOD ROAD		TOWN, MD 21133
Baltimore,	permit. Pages 1 and 2: Department of Health ar Importent: If item 27 is any injury or other treu <u>once.</u>		1 X Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State cemeters	v, crematory or other place)		Location - City or Town, State
<b>≣</b>	mit. F partm sorter injur		21. Signature of Funeral Service License		22. Name and Address of Facility S		NGS MILLS, MD
ä	Deg m e d		Frent -	7	8900 REISTERSTOWN	ROAD - PIKE	ESVILLE, MD 21208
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death. Do n	ot enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	Gram nego	lhve sepsis		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of			2 months
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	nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence o	1): 0		
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0	t the de by the tached	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	o a other (specify)		
٥,	igned be det	by P	Part II. Other significant conditions con	inbuting to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ğ	aquire an sig ould b	edk	Acute renal for	lure		1 ☐ Yes 2	No 3 Probably 4 □Unknown
Records,	law requas been 2 should	Completed	Respiratory fai	ure		24a. Was an	24b. Were autopsy findings available
Ä		mo;				autopsy performed?	prior to completion of cause of death?
Vital	i <b>icien</b> : Th certificate rector, pag	Be (	25. Was case referred to medical examiner?		26. Place of Dea	ath (Check only one)	7 12 103 223 110
of \	sir din	ပ	1 ☐ Yes 2 No H		patient 3 DOA Other: 4 Nursing H	ome 5 Residence	6 □Other (Specify)
	ling P	ion	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Ti	ury Work?	28d. Describe how inju	ry occurred
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Ω	tel or Attsnding Pt s atter death. el Director: After th ed in by the tuneral	Certification:	4 Homicide determined	28e. Place of Injury - At home, farr building, etc. (Specify)	π, street, factory, office	City or Town, State	nd Number or Rural Route Number, a)
	Hospi 4 hour Luner ely till	edical (	29a. Certifier (Check only one) Certifying Phys	ician: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	, and due to the cause(s rred at the time, date an	and manner as stated.  d place, and due to the cause(s)
	To the within 2. To the complete	Me	29b. Signature and title of certifier		29c. License number	29d. Da	tte signed (Month, Day, Year)
			nheusse	Cemp	RE3-000	-	Uly 5 2004
	12		30. Name and ddress of person who cor		ype, Print)		014 ) 2007
_	1 7		Melissa Camp	mo sinai i	tospital of Baltin	none	

Registrar

JUL 0 8 2004

			1 - For State of Maryland / Depar Registrar Cert.	rtment of Health and M rificate of Death	Mental Hygien	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Dorothy T. Beadle		2. Date of Death Month Da July 4,	ay Year 2004 6:40am
	Examir		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis M	40	c. County of Death  Anne Arundel
	Funeral Director		209-10-0307 12 M AX 79 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year, 08/01/19	9. Birthplace (State or Foreign Country)
	with the Maryland or 28a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca  MD Anne Arundel. Annapol			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 28	i Director	10e. Street and Number 84 North Old Bottom Mill Road	10f. Zip Code 21401		itizen of What Country? USA
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Interpreted them 27 is marked other them "naturel", or Items 23s or 28s-f show any injury or other treumatic svent, the Medical Examination must be invitible 1 and once.	by Funeral	1 ☐ Never Married 2 ☐ Married   1 ☐ Yes 2 🔂 No	I as Decedent of Hispanic Origin? (Spi Yes, specify Cuban, Mexican, Puerto ☐ Yes 2 XXIIo Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: white
Baltimore, Maryland 21215-0036	d within 72 h giene. er then "natu , the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  15. Decede (Give ki	nt's Usual Occupation ind of work done during most of work O NOT use retired)  Packaging Opera	ing	Kind of Business/Industry
land	should be filed within nd Mental Hygiene. I marked other than " umatic svent, the Men	To Be (	17. Father's Name ( <i>First, Middle, Last)</i> Joseph Gates	18. Mother's Name	e (First, Middle, Maide en Kelly	n Sumame)
e, Mary	1 and 2 sho Health and N em 27 Is ma ther treuma			Address (Street and Number or Rura Rock Dove Court,	Arnold MO	or Town, State, Zip Code) 21012  Location - City or Town, State
timor	Pages tment of t tent: If its jury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  `4 ☐ Donation 5 ☐ Other (Specify)	Conception Cemetery	20012	•
Ba	Depar Depar Impor any in		21. Signatur Structure Licensee Victor P. Doda, Jr. 22. Charles 150	Name and Address of Facility Arles L. Stevens Fune 11 E. Fort Avenue, Pa	ral Home, Inc ltimore MD 21	230
8760,	Medical Examiner / Medical Examiner / Medical Examiner / Lausi - Lausi	dicai Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):	1 Parlune		Interval Batween Onset and Death
.O. Box 68	Hospital or Attending Physicien: The law requires that the death certifica 4 hours after death. Funeral Director: After this certificate has been signed by the attending pf tely filled in by the funeral director, page 2 should be detached for use as t	Physician/Med		ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ds, P	uires that signed b	by	Part II. Other significant conditions contributing to death but not resulting in the und  Multiple MyElonA	lerfying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
Division of Vital Records,	: The law requir cate has been si , page 2 should	Completed	ANEMIA		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
of Vite	Physicien: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient	3 □ DOA Other: 4 □ Nursing Ho	n (Check only one) me 5 - Residence	6 □Other (Specify)
sion o	ttending P death. stor: After t the funera	Certification:	27. Manner of Death  1	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	
Divi	spital or Atteno ours after deatl teral Director: filled in by the	Certifi	4 Homicide determined 288. Place of Injury - At nome, farm, stree building, etc. (Specify)		City or Town, State	
	To the Hospital within 24 hours a to the Funeral completely filled	ledicai	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investant manner stated.	occurred at the time, date and place, a stigation, in my opinion, death occurr	and due to the cause(s ed at the time, date and	) and manner as stated. d place, and due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
<del>-</del>	N		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr 15n Woods 2001 nedical for	mpous 7635	edi me	21701
:	Sta Registr		31. Date filed (Month, Day, Year)  JUL 0 9 2004  32. Registrar's Signature	who to		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Catherine **Physician** Brosi 7:1500 Jul /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) Examiner Keswick Nursing Home Baltimore | If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth (Month, Day, Year) | 11/03/1909 Birthplace (State or Foreign Country)
 PA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 3/5√F 94 168-05-0938 Yrs Director Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health end Mental Hygiene.

ant: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show ury or other treumatic event, the Medical Examinar must be notitled at 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 □XYes 2 □ No N/A Baltimore City MD Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 5205 Springlake Way 21212 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 1 Yes Selve 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. Specify: white Š 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 0 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Fred Huber Wilhemina Schoessler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Fred M. Brosi / Son 5205 Springlake Way, Baltimore MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition Department of Important: If It any injury or o 1 ☐ Burial 2 ☑ remation 3 ☐ Removal from State BayView Crematory July 6, 2004 Baltimore MD 21230 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) End-Stage demonsters

Due to (or as a consequence of): /Medical Tears **Examiner** Physician/Medical Examine or Attanding Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Willresselvelic Cardisnasenlar assesse with Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Chileaxion, Ristory of congestive Reart and Chronic renal failure 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendity within 24 hours after death.
To the Funeral Director: A complataly filled in by the fi death. 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

M. Helbelle Was Greger D.D 29c. License number 29d. Date signed (Month, Day, Year) D13657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 71. LIBELLE TIACRETOR, 700 W. 40 th STREET, BATTITTORE, TARYLAND 211
31. Date files With, 849 92004 Secretar Signeture **Hegistrar** 

	<u></u>		1 - For State Registrar		State of	Marylar		artmen			and M	lental Hy	giene Rog. Nø?	004	21407
П	Physici	an	Decedent's Name (First, Mid									2. Date of De Month		Year	3. Time of Death 4:55am
,	/Medic		June 4a. Facility Name (If not instituti	F.		hardt		4b City	Town or	Location o	of Death	July 2		County of Deat	
	Examir	ler	Stella Maris			,			oniu		Dodin			1timor	
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.		If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birt	h V Yearl	9. Birt	hplace (State or Foreign
	Director		Devel Conidence of December	1   1	2 F	88	Yrs.	141011113	Days	110013	IVIIII.	8. Date of Bird (Month, Da May 27	1916		
	land ow		Usual Residence of Decedent 10a. State 10b. Coun	у		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Many B-fah	tor	MD Hari	ord			Belair	c							1 Yes 2 No
	ith the	Sire	10e. Street and Number			711		10f. Zip					10g. Citize	en of What Co	untry?
	s 23a	ral	106 South Kel			pt 3			1014				USA		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23a or 28a-f ahow any injury or other traumatic avant. The Medical Examinat must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Ma 3 ★Widowed 4 □ Divorce	rried	Was Dece Amed For 1 Yes If Yes, Give Year or Da	3		Was Deced f Yes, spec I□Yes 2	_	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	cify Yes or No Rican, etc.)		I. Race - Ame Black, White pecify: Wh	e, etc.
2-0	72 ho natur dical	Completed	15. Decede (Specify only high	nt's Educat			16a. Deced	lent's Usua kind of wor	l Occupa	tion	of worki	ag .	16b. Kind	of Business/	Industry
121	within ne.	mple	Elementary/Secondary (0-12)		College (1-	4or 5+)		kind of wor DO NOT us nemake		i i i i i i i i i i i i i i i i i i i	or workin	<i>'</i> 9	Own	Home	
2	filed v Hygie other t	CO	17. Father's Name (First, Middle	, Last)			1101			18. Mothe	r's Name	(First, Middle,	Maiden S	umame)	
an	ould be Mental Marked o	To Be	William Whi		•							cDole	, via idon bi	omamey	
a S	2 shou and M is mar	-	19a. Informant's Name/Relation	ship (Type,	Print)		19b. Mailin	g Address	(Street a			l Route Numbe	or, City or 1	Town, State, Z	lip Code)
Σ,	and 2 ealth m 27 i		Alan Bollhardt	/ Sc	n			· Kel		ve.	-	Air mi	) ZI	014	
Baltimore, Maryland 21215-0036	Pages 1 ment of H ant: If ital		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		oval from S	1210	Place of Dispo- cemetery, cren Ly Cros	natory or ot	her place	10	uly 004	6,		Arlin	Town, State gton, NJ
Ball	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service	Licensee	1			Name and				uneral	Home	Inc.	
	* 4		23a. Part1. Enter the disease,	or complicat	ions that ca	used the deat									nd 21230
١	Physician		Immediate Cause (Final	st only one o	ause on ea	ch line.									Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a		r as a conseq	EMIC CA uence of):	ARDIO	MYOP	ATHY					
	Examiner		Sacuardally list conditions	b											
	sit sit	inei	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2	Due to (d	r as a conseq	uence of):								
	xecut and al-tran	Examiner	that initiated events resulting in death) Last	c.	Due to (d	r as a conseq	uence of);								
9/60	cate be executed physician and the burial-transit	dical E		d											
ρ	tificate ng phys as the	ledi													
C. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣No 9 □ Unknown	23c.	I Live bir	ome of pregna th 2 ☐ Feta nt at time of d wn	I déath 3 🗌	Ectopic pre Other (spe					230	d. Date of deli Month	very Day Year
7	res that I igned by be deta		Part II. Other significant condit	ions contrib	uting to dea	ath but not res	ulting in the un	derlying ca	use givei	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
ras,	w requires been sign should be	ed by										1 🗆 Y	es 2 🗆 !	No 3□Pro	bably 4 Dunknown
ecord	aw Is b	Completed										24a. Was a		24b. Were aut	opsy findings available
r	The ate h	Som	-							-		autop: perfor		death?	ompletion of cause of 2 No
VITai	ician: Th certificate rector, pag	Be (	25. Was case referred to medic examiner?								of Death	(Check only or			
0	Phys this al dii	To	1 ☐ Yes 2 🛣 No 27. Manner of Death	Hos	I 🗀 In		ER/Outpatient			4 LI Nur	-	ne 5 🗆 Resid			HOSPICE
	ding h. After fune	tlon	1 Natural 5 Pend	ng igation	(Month	Injury Day Year)	28b. Time of Injury	M 28	c. Injury Work	at ? es 2.∐N		8d. Describe h	ow injury o	ccurred	
DIVISION	or Attanding after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could	I not be	8e. Place o	of Injury - At ho	ime, farm, stre				-	8f. Location (S	treet and N	√um <i>ber</i> o <i>r Rui</i>	al Route Number,
5	in Direct	Certification:	4 Homicide		buildin	g, etc." (Specify	v)	,				City or Tow	n, State)		
	24 hos 24 hos a Fun etely	edical	29a. Certifier 1 Certify (Check only one) 1 Medica	ng Physici I Examiner	an: To the b On the bas and manne	sis of examinat	wledge, death tion and/or inv	occurred a estigation, i	t the time	e, date and nion, death	place, a occurre	nd due to the c d at the time, d	ause(s) an late and pla	d manner as ace, and due	stated. to the cause(s)
	To the within To the compl	Σ	29b. Signature and title of certifi	er				29c.	License	number	2,5	. 2	9d. Date s	igned (Month)	Day, Year)
	'n		30. Name and address of person											/ /	
	- 0:		DR. TARIO MAH	OOD		DULANEY gistrar's Signa	VALLE	Y RD.	T	MONIU	JM, M	D 2109	3		
	Sta Registr		31. Date filed Mile, Day, Year	2004		gistrar's Sigila	_	A							
DHI	MH 17 Rev 1/20				/		/	Span	Es/						

2004

JUNE BOLLHARDT

Physician Doris Rose Roll Month Day Year			1 - For State Registrar	State of Mar	yland / Depa	artment of Heartificate of De	ith and M	ental Hyg	iene	04	21408
Boly Cross Rospitcal  Sales Secretive Management  297-12-6997  100 age 7, Age (forms between 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	/Medic	al	Doris Ro	se Be	11	Ah City Town or Loo	ation of Dooth	Month	Day 6	2004	3. Time of Death 2:28 PM
Dec. 29,1922 Onto   Dec. 29,1922 Onto   Dec. 29,1922 Onto   Onto Nontgomery   10c. City, Town or Location   10c. Celes City United States	Funeral	er	Holy Cross Hospi  5. Social Security Number 6.	.ta1 Sex 7. Age (		Silver	Spring	8. Date of Birth	Mo:	ntgom	
Thomas   Lee   18 Mother's Name (First, Middle, Last)   Thomas   Lee   18 Mother's Name (First, Middle, Last)   Thomas   Lee   18 Mother's Name (First, Middle, Last)   Thomas   Lee   19 Mailing Address (Sireer and Number or Plant)   Prances   Rose   Ro	0	,	Usual Residence of Decedent		01			Dec. 29	,1922	0	hio
Thomas   Lee   18 Mother's Name (First, Middle, Last)   Thomas   Lee   18 Mother's Name (First, Middle, Last)   Thomas   Lee   18 Mother's Name (First, Middle, Last)   Thomas   Lee   19 Mailing Address (Sireer and Number or Plant)   Prances   Rose   Ro	or 28e-f sl	irector		ery			Spring	10	Dg. Citizen of	What Cour	
17. Fisher's Name (First, Middle, List)   17. Fisher's Name (First, Middle, List)   17. Fisher's Name (First, Middle, List)   17. Fisher's Name (First, Middle, List)   18. Mailing Address (Sireer and Number or Plural Route Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number or Plural Route Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number or Plural Route Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number or Plural Route Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Mailing Address (Sireer and Number, Crip or Town, Safe, Zp Code)   19. Maili	ems 23a c	ınerai D		12. Was Decedent Eve	er in U.S. 13.			ify Yes or No-	14. Rac	ce - Americ	an Indian,
17. Faither's Name (Frist, Middle, Last)   17. Faither's Name (Frist, Middle, Last)   17. Faither's Name (Frist, Middle, Last)   18. Motine's Name (Frist, Middle, Makides Summere)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State, Zp Code)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State)   19. Mailing Address (Street and Number or Paul Boule Number. Cryo Town, State)	turel', or It	ed by Fu	3	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No Sp	pecify:		Specif	y: Wh	ite
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1   Dural 2   2004   Beltsville, MD	Heelth and P om 27 is me her treume		Linda Kay Bell/	Daugter	9015	Linton St.	, Silve	r Spring	g, MD	2090	01
23a. Part I Errel the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Balveen check of their failure. List only one cause on each sine.  Part and a cause (Final resulting in death)  Sequentially list conditions, cause. Enter Underlying cause or injury cause (principle or cause). Enter Underlying cause or injury cause (principle or cause). Enter Underlying cause or injury resulting in death) Last  Per Balactic Cause (Disease or injury cause or i	artment of H ortent: If ite injury or of		1 ☐ Burial 2 ☑ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci	(y)	Chesapeak	e Crematory	July 7 2004	8	Belts	ville	
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Sequentially list conditions, a my, te a fine 1 seminal state and garden property of the initiated events resulting in death) Last  Large Hiatal Hernia with Volvulus  Large Hiatal Hernia with Volvulus  Sequentially list conditions, a my, te a fine 1 seminal state and part of the minimum and the first part of the firs			Immediate Cause (Final disease or condition	a. Pneumo	nia	er the mode of dying, suc	ch as cardiac or	respiratory arre	st,		Interval Between Onset and Death
Renal Insufficiency    Renal Insufficiency		Jer	Sequentially list conditions, if any, leading to immediate	Large	Hiatal He	ernia with	Volvulus	3			days
FFEMALE:   23c. Mas decedent pregnant in the past 12 months?   1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown			that initiated events	Due to (or as a co	onsequence of):						years
236. Did tobacco use contribute to the cause of death?    1	as the bu	ledicai		d. Renal	Insuffici	ency					years
236. Did tobacco use contribute to the cause of death?    1	by the attendir ached for use	hysician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3						•
24a. Was an autopsy performed? 1   Yes 2   No  25. Was case referred to medical examiner? 1   Yes 2   No  26. Place of Death (Check only one)  27. Manner of Death 1   Natural   5   Pending investigation   3   Suicide   4   Homicide   4   Homicide    28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work? 2   Accident   3   Suicide   4   Homicide   28c. Place of Death (Check only one)  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  29d. Certifier (Check only one)  29d. Certifier   29d. Certifier   29d. Certifier   29d. Certifier   29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	engi-	Š	Part II. Other significant conditions of	contributing to death but n	ot resulting in the un	derlying cause given in f	Part I.				
Saminer?    Yes 2   No   Hospital: 1   Impatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)    Yes 2   No   Hospital: 1   Impatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)    Yes 2   No   Saminer of Death   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   No   1   Yes 2   No   1   Yes 2   No   28c. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)    Yes 2   No   28d. Describe how injury occurred   28d. Descri	ate has page 2							autopsy performe	ed?	prior to com l <u>ea</u> th?	pletion of cause of
27. Manner of Death 1 Natural 2   Accident 3   Suicide 4   Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M 1   Yes 2   No  28c. Injury at Work? M 1   Yes 2   No  28d. Describe how injury occurred  28d. D	direction of	0	examiner?	Hospital: 1 XInpatient	2 ER/Outpatient	Other				er (Specify)	)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and the course of the cause (s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  D50987  July 7 - 2004	death. tor: After the funera	cation:	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injury	M 1 Tyes	2 🗆 No				
D50987 July 7, 2004	ours after	S Certif	4 Homicide determined	building, etc. (S	Specify)			City of Town,	State)		
D50987 July 7, 2004	the Fur	Medica	one) 2 Medical Exam	niner: On the basis of exa	amination and/or invi	estigation, in my opinion,	, death occurred	at the time, date	e and place, a	nner as sta and due to t	ited. the cause(s)
		2	40			D509		290			,

			1 - For State Registrar	State of Maryla		artment of F rtificate of			giene	211.00
	Physic	ian	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day Vo	3. Time of Death
	/Medi	cal	Elizabeth  4a. Facility Name (If not institution, give s	eter at and aumborl	Bot		-1	July	07 200	4 2:40 9 M
1	Exami	ner	Stella Maris Mer			4b. City, Town, o	imore	atn •	4c. County of E	
	Funeral	Г	Social Security Number	7. Age (In yr.	s. last birthday)	If Under 1 Year	If Under 24 H			Birthplace (State or Foreign Country)
	Director		210-14-7033	M 2 🗗 81	Yrs.	Months Days	Hours Mi	9-13-2	22	Ga.
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
	a-fsh	ctor	Md. NA	B	altimor	·e				Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
	e 23a	eral	5430 Park Heights			21215			USA	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importents: If item 27 is marked other then "naturel", or iteme 23a or 28a-f show any injury or other treatments event, the Marical Exercites trivial by profiled at ODGE.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba I □ Yes 2X No	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- irto Rican, etc.)		merican Indian, /hite, etc. Black
2-0	72 hou	eted	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	lent's Usual Occup	ation		16b. Kind of Busine	ss/Industry
21215-0036	ed within giene.	Completed	Elementary/Secondary (0-12) 5th grade	College (1-4or 5+)		kind of work done DO NOT use retired itress	during most of w	orking	Horn & H	lorn
Maryland	uld be file Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Shelton	Jam	es		18. Mother's Na Lucy	ame (First, Middle, I	Maiden Sumame) James	3
Man	l 2 sho and i Is me		19a. Informant's Name/Relationship (Typ					Rural Route Number		e, Zip Code)
	1 and Health		Vera Graham  20a. Method of Disposition	Niece 20b.	J81 Place of Dispos	reduce to the	Rd., Rar	dallstown	1, Md. 2]	.133
ē	Pages nent of H ent: If ite ury or of		1 Burial 2 □ Cremation 3 □ Re  1 4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, cren	Forest	' 1		Owings Mi	
Baltimore,	permit. Departm Importe any inju		21. Signature of Funeral Service License		22	Name and Addres	ss of Facility	Bal	timore, M	id. 21202
	Physician /Medical Examiner	Examiner	23a. Part. Enter the disease, of complice shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		quence of):			H Cay C		Approximate Interval Between Onset and Death
Box 68760,	death certificate be executed e attending physician and of for use as the burial-transit	edical	d.	Due to (or as a conse					23d Data etc	
P.O. Bo	0 00	Physician/M	in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown		Ectopic pregnancy Other (specify)			23d. Date of d Month	Day Year
Ś	The law requires that the te has been signed by the age 2 should be detache	by	Part II. Other significant conditions cont	ributing to death but not re	sulting in the un	derlying cause give	en in Part I.			to the cause of death?  Probably 4 Unknown
Vital Record	G CL	e Completed	25 Was save referred to a referr					24a. Was an autopsy perform 1 Yes 2	prior t death	autopsy findings available o completion of cause of es 2 \( \text{No} \)
ō	Phys this aldii	ToB	25. Was case referred to medical examiner?  1 Yes 2 No Ho  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	at University	ath (Check only one Home 5 Resider 28d. Describe how	nce 6 Other (Sp	pecify) hospice
DIVISION	Hospitel or Attending 14 hours after death. Funerel Director: After tely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,
	ths Hospitel iin 24 hours the Funerel pletely filled	ledical	one)	cian: To the best of my kn- er: On the basis of examination and manner stated.	owledge, death ation and/or inve	occurred at the timestigation, in my op	e, date and place inion, death occi	a, and due to the cau	use(s) and manner te and place, and di	as stated. ue to the cause(s)
	To the within 2.	Σ	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mo	nth, Day, Year)
	~	-	30. Name and address of person who com	Man My	<u> </u>	170,	1430		July /,	2004
	8		our Name and address of person who com	Foldywan	m 23a) (Type, P		101. 10F	Bold	imair	md 21207
	Star Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sign		bouls	•	10911		00 (1202

DHMH 17 Rev 1/2001

BoHS, ELizabeth

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JUTY 6, 2004 Year Barbara H. Bremer 5:15 р м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Ivy Hall Nursing Home Middle River Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth NOV • 28 1914 **Funeral** 9. Birthplace (State or Foreign Days Hours Min 1 M 2 F Conffecticut 047-09-4743 89 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow the Medical Executiver count by notified at Director 1 ☐ Yes 2 ☐No Md. Harford Fallston 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2317 Furnace Road 21047 United States or Items 23a death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity: þ 3 X Widowed 4 ☐ Divorced Specify: white natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) secretary insurance 12 years 17. Father's Name (First, Middle, Last) other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth eny injury or other traumatic event ang. 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Henry unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory E. Bremer/stepson 2317 Furnace Road, Fallston, Md. 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) July 8, 2004 Bayview Crematory Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. relle 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition shalle Physician /Medical resulting in death) Due to (or as a consequence of) Examiner un knoon 00 homi ( Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical as IF FEMALE: esn nse 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. | ☐ Yes 2 ☐ No the detached 9☐Unknown 9 Unknown ρ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 90 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page certificate 1□ Yes 2☑ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Drawing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 2 Accident after death Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours a To the Funeraf I filled Hospital 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the ! 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN BLVD. MALIKA INASCEM M.D. 709. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

)			For Unpend Item	#State of Maryland / Der #23a & #27 ryland / Der Per in Ce		Mental Hygier	_	0 / / / /
	£,		Registrar  1. Decedent's Name (First, Middle, Las		ertificate of Déath	2. Date of Death		3. Time of Death
	Physicia /Medic		Benjamin	F. Baldwin			6, 2004	2:47P. M
	Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea		4c. County of Dea	
		Α.	FRANKLIN SQUARE HO  5. Social Security Number 6. Se		ESSEX  v) If Under 1 Year   If Under 24 Hr		BALTIMORI 9. Bir	
	Funeral Director			XM 2□F 54 Yrs.	Months Days Hours Mir	8. Date of Birth (Month, Day, Yee Mar. 14 195	50 Mar	thplace (State or Foreign ountry) yland
	with the Maryland a or 28a-f show Le notified at	or	10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28a-	Funeral Director	Maryland Baltimor  10e. Street and Number	e Essex	10f. Zip Code	10g. (	Citizen of What Co	
	th with 23a o	a D	816 Briar Hill Pl	ace Apt G	21221			USA
	r death	Iner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	
900	be filed within 72 hours after death with the Marylan at all Hygiene. And the William at the William at the William as seent, It a Medical Evaluation must be redified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 MNo If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify:	White
Maryland 21215-0036	within 72 h ene. than "natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) (Giv	edent's Usual Occupation ve kind of work done during most of w . DO NDT use retired)	orking 16b.	. Kind of Business	s/Industry
21	filed wit Hygiene ther the	Com	12	S	Supervisor			t Maintenanc
pu	be file tal Hy d oth svent	Be	17. Father's Name (First, Middle, Last)			ame (First, Middle, Maid		
yla	should be bd Mental marked c	2	Benjamin Franklin			oris Mae Whi		7'- 0 - 4-1
	is 1 and 2 should of Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relationship (7 Debra Lynn Baldwi	n (wife) 816	iling Address (Street and Number or F Briar Hill Place		-	
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☑▼remation 3 ☐		position (Name of rematory or other place)		Location - City or	
Ë	nit. Pag lartment ortant: injury c injury c		`4 □ Donation 5 □ Other (Specify	Bayview	Crematory INC 7/1			
Bai	permit. Page Department of Important: If any injury or		21. Signiture of Fundral Socyice Light		22. Name and Address of Facility E 407 Old Eastern A			
	Pnysician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final diseas - r condition resulting in death)	plications that caused the death. Do not e one cause on each line.  a. Atherosclerotic C  Due to (or as a consequence of):				Approximate Interval Between Onset and Death
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):				
,092	ite be executed sysician and ne burial-transit	icai Exa	resulting in death) Last	Due to (or as a consequence of):  d.				
.O. Box 68	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B □Ectopic pregnancy S □ Other (specify)		23d. Date of de Month	olivery Day Year
Ω.	ires that the signed by	by	Part II. Other significant conditions c	contributing to death but not resulting in the	underlying cause given in Part I.			o the cause of death?
0.00	v requir been s should	eted						
I Records,		Completed				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of s 2 No
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	Othor	eath (Check only one)		
of	Phys this ral dir	- To	1X Yes 2 No 27. Manner of Death	I Inpatient 2 A EN Outpati	GILL SELDON 4 INGISING	Home 5 ☐ Residence 28d. Describe how in		ecify)
Division	or Attending I ifter death. Director: After in by the funer	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury				
Divis		Certification:	3 Suicide 6 Could not be 4 Homicide determined		street, factory, office	28l. Location (Street City or Town, Sta	and Number or Ri ate)	ural Route Number,
	HO H T H	Medical (	29a. Certifier (Check only one) 1 Certifying Ph	nysician: To the best of my knowledge, deniner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occurred.	e, and due to the cause curred at the time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)
	within 2 o the complet	ğ	29b. Signature and title of certifier	4	29c. License number	29d. [	Date signed (Mont	th, Day, Year)
)	N h		> Quell		O.C.M.E.	JUL	Y 7,2004	<u> </u>
1	56		ANA RU	completed cause of death (Item 23a) (Typ	111 Penn Street,	Baltimore,	Marylan	nd 21201
	Sta Registr		31. Date filed (Venth Coap Y2004	32. Registrar's Signature	ke			

Amend Item/Pase Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-04381 1- For Amend Item #4b State of Maryland 49 partment of Health and Mental Hygiene Registrar ΑE 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** John David Bridendolph, Jr. July 2004 4 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Laurel Regional Hospital Boltsville Laurel Prince Georges If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 27, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 11XM 2□ F Yrs. 35 Director 579-98-6536 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Maryland Prince George's Beltsville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itams 23g 4824 Quimby Avenue 20705 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 XX Yes 2 □ No 199
If Yes, Give Year or Dates: 199 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) Black, White, etc. 1991-1 Never Married 2 X Married ò 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced "natural", White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hillandale Shell 12 Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ant: If itam 27 Is marked otl David Bridendolph, Sr. Twvlene Corcoran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene A. Bridendolph - Wife 4824 Quimby Avenue, Beltsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. MD Veterans Cemetery 07/12/2004 Cheltenham, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licenses Dasch Landy 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypertensive Cardiovascular Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the burial-transit that initiated events resulting in death) Last signed by the attending physician and Due to (or as a consequence of): P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 🗆 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 Tyres 2 □ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide ō To the Hospital within 24 hours a To the Funeral L 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title OCME July 5,2004 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address MANG. APPLYN

31. Date filed (Month, Day, Year)

32. Registrar's Signature 111 Penn Street, Baltimore, Maryland 21201 State 0 8 2004 Registrar DHMH 17 Rev 1/2001

unpend item#23a,27,PER ME.

John Bridendolph

2 more pendin

C833,7/22/04eg

IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death

4□Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery

24a. Was an autopsy performed?

2 No

1 Yes

26. Place of Death (Check only one)

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Day Year

24b. Were autopsy findings available prior to completion of cause of death?

1 res 2 No

6:13a

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 XYes 2 No

21207

MD Approximate Interval Between Onset and Death

FLORIDA

BLACK

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1X Yes 2 □ No

27. Manner of Death

2 Accident

3 ☐ Suicide

4 Homicide

(Check only

1 Natural

Hospital: 1 Inpatient 2 XER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation 7/6/04

28b. Tim**Found** 28c. Injury at Work? 6:02 a<sup>M</sup>

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d Describe how injury occurred **Subject behaving eratically**, restrained by police

and Number or Rural Route Number.

3700° blk Hanover Street, Baltimore, Maryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Treerber

street

29c. License number OCME

29o. Date signed (Month, Day, Year) JULY 06, 2004

Josha! 30 Name and address of person who completed cause of death (frem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 Iasha MD

31. Date filed (Month, Day, Year) State

6X Could not be

determined

d2. Registrar's Signature

Registrar

as

use

signed by

has page certificate !

this

after death.

Director: Aff

within 24 hours a To the Funerel I

by

Completed

Be

2

Certification:

Medical

P.O.

of Vital Records,

Division

To the Hospitel or Attending

**ORIGINAL** 

B.K.S HARRY GLENWOOD COLLINS

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

KY	GLENWO	עכ	COLLINS  1 - For AMEND Item Registrar	State of	Maryland / Depa	artment	of H	ealth a	and Me	-	- 43		011
			Registrar  1. Decedent's Name (First, Middle		, 4000, 17 9/0 <del>8</del>	rineate	OT L	Jeatn		2. Date of De	Reg. No	UUL	3. Time of Death
	Physici		HARRY GLENWOOD							Month JULY	Day	, Year 004	11:50 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution 4210 St.GEORG	n, give street and num SES AVENUE	ber)			Location o			4c.	County of Death	
	Funeral Director	Q.	5. Social Security Number 212 44 5606	6. Sex 1 [x] M 2 ☐ F	7. Age (In yrs. last birthday) 59 Yrs.	If Under Months	1 Year Days	If Under Hours	Min	B. Date of Bir (Month, Da AN. 23	th y, Year)	9. Birthi Coul 9. Birthi P. Birthi Coul	place (State or Foreign nto) LAND
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo	cation							10d. Inside City Limits
	the Marylan 28a-f show	tor	MD N/A		BALTIMORE								1¶Yes 2□No
	th the or 28a e noti	Director	10e. Street and Number			10f. Zip					10g. Cit	izen of What Cou	ntry?
	s 23s	rai	4210 ST. GEORGE			2121					U.S.		
"	72 hours atter death with the Maryland naturel', or Items 23s or 28s-f show diest Evantret must be notified at	Funerai	11. Marital Status 1 □ Never Married 2 🖔 Mar	12. Was Deced Amed For	INO EJISTE I					fy Yes or No can, etc.)	-	14. Race - Ameri Black, White,	
903	rel', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	, , ,	1 ☐ Yes 2	No No	Specify:				Specify: BL	ACK
215-0036	"natu	ietec		nt's Education est grade completed)	(Give	dent's Usua kind of wor DO NOT us	k doné a	uring mos	t of working	7	16b. K	ind of Business/In	ndustry
212	d within	Completed	12th (0-12)	College (1-	4or 5+) MAINTI		,				APAR	RTMENT BU	JILDING
pu	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryla Department of Health and Mantal Hygiena. Important: If item 27 is marked other than "naturel", or Items 23s or 28a-1 show any injury or other traumatic avant, I'm Medical Eranical must be notified any once.	a	17. Father's Name (First, Middle, GLENWOOD HARRY	Last) Harry	G. Collins I		1		er's Name (	First, Middle,	Maiden	Sumame)	
Maryland	d Men marka matic	မှ	19a. Informant's Name/Relations			na Address					er City o	r Town, State, Zip	n Code)
	nd 2 salth an 27 is i		ELSIE COLLINS (			-							AND 21239
Baltimore,	es 1a of Hea fitam rotha		20a. Method of Disposition 1 □ Burial 2 🂢 Cremation	3 □ Removal from S	20b. Place of Dispo	sition (Nam	e of	T	Dat	-		ocation - City or To	
tim	: Pag tment tant: I		□ Donation 5 □ Other (S	Specify)	GARRISON					4, 200	4 E	ALTO, M	RYLAND
<u>8</u>	permi Depa Impo any ir	1	Signature of Funeral Service	Licensee	numeron man	2. Name and			, C				FUNERAL HOM: YLAND 21213
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that ca	used the death. Do not ent							VII. LIVI	Approximate Interval Between
8	Physician		Immediate Cause (Final disease or condition	comy one dadds on da		CINO	mA						Onset and Death
	/Medical Examiner		resulting in death)	Due to (d	or as a consequence of):								
L		jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (c	or as a consequence of):		_						
	ecuted and I-transit	Examiner	that initiated events	<b>S</b> c									
8760,	ate be executed hysician and the burial-transii	ai Ex	resulting in death) Last	Due to (d	or as a consequence of):								
687	iticate g phys as the	edicai		d									
Вох	death certitics attending phate to use as the	an/M	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy	Ectopic pre	gnancy					23d. Date of delive	•
.O.	The law requires that the death certiticate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregna 9□Unkno		Other (spe	ecify)					MOHIT	Day Year
<b>a</b>	uires that the designed by the		Part II. Other significant conditi	ons contributing to de	ath but not resulting in the u	nderlying ca	tuse give	n in Part I		23e. Did t	obacco u	ise contribute to t	he cause of death?
rds	w requires been sign should be	ted b	ATM ERISCLER	otic can	DENTSCHEM	015	EAR	8		10	/es 2\	Prob	oably 4 □Unknown
Records,	e law re has be je 2 sh	Completed by								24a. Was autor	SY	prior to co	opsy findings available impletion of cause of
<u>a</u>		e Cor	25. Was case referred to medical								rmed? 21 <b>2</b> No	1 Yes	2 🗆 No
Vital	S 0 10	0 8	examiner?  1 Yes 2 No	Hospital	patient 2 ER/Outpatier	nt 3 🗆 DO	A Othe			Check only o		Other (Specif	AT SCENE
n of		on: T	27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date o (Month	f Injury o, Day Year) 28b. Time o Injury		Bc. Injury Work	:?		d. Describe I	now injur	y occurred	
Division	Attending r death. actor: After by the fune	Certification:	2 Accident invest 3 Suicide 6 Could		of Injury - At home, farm, sti	M eet. factory		/es 2□		f. Location (	Street an	d Number or Rura	al Route Number.
Div	al or A s atter il Dira	Certi	4 Homicide determ	buildin	g, etc. (Specify)	, , , , , ,	,			City or Tox	vn, State	)	
	To the Hospital or Attanc within 24 hours atter death To tha Funaral Diractor: completely tilled in by the	edical (			best of my knowledge, deat sis of examination and/or in er stated.								
	To the within 2 To tha complet	Me	29b. Signature and title of certific	4//			O.C.					e signed (Month,	
	<b>h</b>		· //	You			U•C.	•141 • T			JU	JLY 2, 2	200 <del>4</del>
	9		MARGARI	PPLE, ND			æet,	, Bal	timor.	e, Mar	ylar	nd 21201	
	Sta Registr		31. Date filed (Month, Day, Year JUL 09		gistrar's Signature	Sa	Z/s						

04-04316 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Unpend Item #23262/ per med Constitution of Health and Mental Hygiene Registrar Willie Carson **RJD** 2. Date of Death 1. Decedent's Name (First, Middle, Last) JUIY 02, Da 2004 **Physician** 0250A. Carson Willie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2815 Walbrook Ave. Baltimore 6. Sex 1 M 2 ☐ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 50 **Director** 227-72-9295 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-1 show item 27 is marked other than "natural", or itame 23a or 28a-f show other treumatic event, the Modical Execution of the positived at Director Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 USA Be Completed by Funeral 2815 Walbrook Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9th grade Never Worked NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) is marked o Odell Drewry Carson McKinley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20019<sup>Apt. 302</sup> Department of Heelth a importent: if item 27 is any injury or other tree once. 4046 Grant St N.E., Washington, D.C. Carolyn Williams Sister 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition

1 3 Removal from State 20c. Location - City or Town, State 7-9-04 Garrison Forest Vet Owings Mills, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. Wane March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Physician /Medical Examiner use as the burial-transit signed to page

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, efter death. filled in by within 24 hor To the Fune completely fi

	Immediate Cause (Final disease or condition		Onset and t	Jeam				
	resulting in death)	Due to (or as a conseque	ance of):					
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conseque	ance of):					
alcai Exa	resulting in death) Last	Due to (or as a conseque	ence of):					
nysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal ( 4 Pregnant at time of dea	death 3 □Ectopi	c pregnancy (specify)		23d. Date of de Month	,	Year .
eted by Pr	Part II. Other significant conditions of	contributing to death but not resul	ting in the underlyin	ng cause given in Part I.		acco use contribute to		leath? Jnknown
Comple					24a. Was an autopsy perform	ed? prior to death?	utopsy findings a completion of ca s 2 No	available ause of
ge	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one	)		
0	1x Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residen	ice 6 Other (Spe	ecify) (scen	ie)
ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how	v injury occurred		
Certific	3 Suicide 6 Could not b 4 Homicide determined		ne, farm, street, fac	tory, office	28f. Location (Stre City or Town,	eet and Number or F State)	ural Route Num	ber,
edical		nysician: To the best of my knowniner: On the basis of examination and manner stated.						)
ž	29b. Signature and title of certifier	^		29c. License number	290	o. Date signed (Mon	th, Day, Year)	
	1/ / / / / / / / / / / / / / / / / / /	who		O.C.M.E.	i	July 02, 2	2004	

111 Penn Street, Baltimore, Maryland 2120

۷a.

X Yes 2 No

21202

State

Registrar

30. Name and address of person who completed cause

(o) Che

APON

Date filed (Month, Day, Year)

JUL 0 9 2004

of death (Item 23a) (Type, Print)

			for State Registrar	State of M	laryland / [		nt of He		-		) N L	21617
	Physic	ian	1. Decedent's Name (First, Middle,	Last)		17.1.4			2. Date of D Month	100	Year	3. Time of Death
	/Medi		Joanne Cogar								5,200	4 4:22A A
	Exami	ner	4a. Facility Name (If not institution, Saint Josep	-			Town, or Lo	TOWS	on	4c. Co	unty of Death Balt	timore
	Funeral Director		214-78-5482	6. Sex 7. Ag 1 ☐ M 2 <b>/∑</b> /€	ge (In yrs. last birt	rhday) If Under Months		f Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Nov. 13	rth ay, Year) ,1965		place (State or Foreig intry) achusetts
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	a-fsh	tor	Maryland Baltin	roe	Middle	River						1 □ Yes 2 No
	or 28	Sire	10e. Street and Number			10f. Zip	Code			10g. Citizen	of What Cou	intry?
	s 23a	rai	10231 Bird River				21220			U.S.A	•	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Importent: If item 27 is markad other then "naturel", or Items 23a or 28a-f show shi injury or other traumatic event, the Modical Existing at must be notified at once.	by Funeral Directo	11. Marital Status  1 Never Married XX Marrie  3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1 □ Yes 2 If Yes, Give Year or Dates:		13. Was Deced If Yes, spec		anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or Ne Rican, etc.)		Race - Ameri Black, White, ecify: Wh	
21215-0036	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)			Decedent's Usua (Give kind of wo. life. DO NOT us	al Occupation rk done duri se retired)	on ing most of worki	ing	16b. Kind o	of Business/In	ndustry
22	iled w Hygiei thar ti nt, to		12 17. Father's Name (First, Middle, L	acti	Cl	erk	4.0	N 14-41 . J 11	75°		al Bil	ling
Maryland	d 2 should be filed within h and Mantal Hygiene. 7 Is marked other then "traumatic event, the Me.	To Be	John Atkins					3. Mother's Name lorence		, Maiden Sur	патө)	
	and 2 sho salth and n 27 Is m		19a. Informant's Name/Relationshi Ronald Cogar (Hu					Number or Rura				nd 21220
ore,	of Head		20a. Method of Disposition		20b. Place of	Disposition (Nan	ne of	1	ate		on - City or To	
Baltimore,	Pages ment of ent: If it		XXBurial 2 ☐ Cremation : '4 ☐ Donation 5 ☐ Other (Sp.	ecify)				r. July	9,2004	Balti	more, 1	Maryland
Ball	permit. Departr Importe eny inji		21. Signature of June 112 et (ice Li	censee		22. Name an	d Address of Bruzo 1d Eas	of Facility dzinski stern Av	Funera enue	l home	'Mar∆ı	and 21221
Marie III	Pnysician /Medical Examiner	J.	23a. Party Enter the disease, or of shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. <u>CARDII</u> Due to (or as	the death. Do note.  ORESPI a consequence of MYELITI a consequence of	RATORY		EST	r respiratory a	rrest,		Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. EHRINL	a consequence of	Enti	130E					
9	e as t	0	IF FEMALE:									
.O. Box	at the death certifics by the attending place tached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pre 5 □ Other (spe					Date of delive Month	e <b>ry</b> Day Year
ď.	es that igned b	by Pi	Part II. Other significant condition	s contributing to death be	ut not resulting in	the underlying ca	ause given ir	n Part I.	23e. Did to	obacco use c	ontribute to th	ne cause of death?
ord	w require been sig should b	ted t	CORONARY ARTER	Y DISEASE					101	res 2XNo	3 ☐ Prob	ably 4 Unknown
of Vital Records,		Completed	PERIPHERAL VASO	CULAR DISEAS	SE						prior to cor death?	psy findings available npletion of cause of 22 No
Vita	Physician: This certifical director, p	Be	25. Was case referred to medical examiner?	Hospital:				. Place of Death				70-71
oţ		T: To	1 Yes 22 No 27. Manner of Death	28a. Date of Injur	y 28b. Tir	ne of 28	A Cultury at	4 Nursing Hom	e 5 Resid			/)
ion	Attending I r death. ector: After by the funer	atior	1 Natural 5 Pending 2 Accident investiga	(Month, Day		ury M	3c. Injury at Work? 1 ☐ Yes	2 🗆 No	od. Describe r	iow injury occ	,0.1100	
Division	or Attendate death Director:	Certification;	3 Suicide 4 Homicide  Could not be determined  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)								l Route Number,	
	Hospite 4 hours Funerel ely fille	Medical C	29a. Certifier (Check only one)	Physician: To the best of raminer: On the basis of and manner sta	examination and	death occurred a or investigation,	it the time, o	date and place, are on, death occurre	nd due to the o	cause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)
)	To the To the Complet	ž	29b. Signature and title of certifier	111	) W		License nu		-	29d. Date sign		A
		1	30. Name and address of person wh	o completed cause of de	eath (Item 23a) (T		D 318	326		1-6	e -0	
	7		PICHARD L. L	TAITLIT CHIM A	d T) =7/	590, 1 mily	en en en en	STIET TO	1-1-1-24	475.75571 ·	nam =	4 m/a-k
	Sta	0.70	31. Date filed (Month, Day, Year)		ır's Signature	, ,			WaCiN i	mar I Li	HIND C	1504
DHA	Registra MH 17 Rev 1/20	1.49	JUL 09:	2004	wa p	5 Sp.	als	<u>/</u>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 8 2004 10:15AM Brian Edward Cotter Julv /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Joseph Richey Hospice If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1፟፟∭M 2□F Days Hours Min. Director 215-76-9348 44 25, Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County in then "neturel", or Items 23e or 28e-f ehow The Madical Examiner must be notified at 1X Yes 2 No Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2957 Keswick Road 21211 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Ď 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Wireman Electronic 12 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Thomas J. Cotter Joann H. Sherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any injury or other treum once. Larry Evener/Friend 2957 Keswick Road Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/09/04 Metro Crematory Inc. Baltimore, MD <sup>4</sup> □ Donation 21. Signature of Funeral Service Ligensee

Nomo

Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ung cancer Physician Meta /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate tause. Enter Underlying Due to (or as a consequence of): Examiner cause (Disease or injury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? I Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be HOSPICE Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b Time of 27. Manner of Death Certification: After al or Attending F after death. 1 Natural 5 Pending М 1 ☐Yes 2 ☐No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel Completely filled in Ecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier D24170

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ETSO MD Richey Hospice 838 NEwaw St Battimore MD

32. Registrar's Signature

			For		State of Ma	-	epartment of		Mental Hygie	ene	
	,		1 - State Registra				Certificate of	Death	Reg	1 MS: () ()	3. Time of Death
	Physici		1. Decedent's	Name (First, Middle,	Last)		Char	manl	Month July	Day Year 5	2:15 PM
	/Medic Examin		4a. Facility Na	ame (If not institution,	give street and number)		4b. City, Town,	or Location of Death		4c. County of Dea	
			5. Social Sec	-on as	TOPKINS 6. Sex 7. Ag	HOSPIT	AL BAL Iday) If Under 1 Year	If Under 24 Hrs.	City 8 Date of Flith	Q Ri	rthplace (State or Foreign
	Funeral Director	35	145-5	8-4891	1 □ M 25 F		rs. Months Days		8. Date of Birth	8 10	HA Cardina
	and		Usual Reside	ance of Decedent 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Maryl	tor	MD			Balt	imore				1 ♠ es 2 No
	with the Maryland a or 28a-1 show	Funeral Director	10e. Street a	nd Number	200 (1)		10f. Zip Code	205	10g	. Citizen of What C	ountry?
	death v	eral	11. Marital Si		290 Stra	Ever in U.S.	13. Was Decedent of If Yes, specify Cui	Hispanic Origin? (S	pecify Yes or No-	14. Race - Am	
õ	or Iter			or Married 2 Marrie	If Yes, Give	lo l	1 Yes, specify Cui		o Rican, etc.)	Black, Whi	te, etc.
-UU30	2 hours after sturel', or ite	ed by	3 ∐ Wido	owed 4 Divorced	Year or Dates: s Education	16a. I	Decedent's Usual Occu	pation	16	b. Kind of Business	//////////////////////////////////////
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7	Hygier Hygier Ither It	Cor	17. Father's h	Name (Frst, Middle, L	ast) JUPS	(	aseu	18. Mother's Nan	ne (First, Middle, Me	iden Sumame)	XPOI CE
an	uld be Mental rked o	To Be	Will	ierNe	Kirk			Bess	sieN/e	WKITL	_
nary	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. item 27 is marked other then "neturel", or items 23a or 28a-1 show other treumetic event, if a M. Jica Exacili er is at the neitlised at	•	19a. Informa	nt's Name/Relationsh	ip (Type, Print)	19b.	Mailing Address (Stree	and Number or Ru	ral Route Number, (	City or Town, State,	Zip Code)
ق ق	Health Health tem 27 other t			of Disposition	OKTORIA	20b. Place of I	<b>33 APNN</b> Disposition (Name of	erst-Kic	QQ 1000 Dale 20	c. Location - City or	YA 2303 T Fown, State
Ē	9° = 5			al 2 Cremation ation 5 Other (Sp	3 □Removal from State ecify)	M+7	crematory or other pla	tory 7/	10/04 B	citimo	re. MD
Salt	permit. Pag Department Important: any injury once.		21. Signatur	e o Funeral Service L	iceosee L	1 11 C	Paugh Ad	oss, of Creek	je Fruer	al Servi	des
	40 ± 8 9		23a. Part1. I		complications that caused		ot enter the mode of dy	hg, such as cardiac	or respiratory arres	MD 21	Approximate
	Physician		shock, Immediate C disease or c	Cause (Final	nly one cause on each light	om in	n/ S	rensis			Interval Between Onset and Death
	/Medical Examiner		resulting in o	leath)	a. Don's (or as	a consequence of	7:				J. DECERS
		er	Sequentially if any, leading	list conditions,	b. Due to (or as	a consequence of	<u> 1 SC</u>	riemi	<u> </u>		2 weeks
	cuted nd ransit	Examiner	Cause (Dise that initiated	r Underlying ase or injury events	c						
8/00,	ate be executed thysician and the burial-transit		resulting in d	eath) Last	Due to (or as	a consequence of	f):				
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X D	death certificate e attending phys d for use as the	Physician/Me		ecedent pregnant ast 12 months?		2 Fetal death	3 □Ectopic pregnanc	су		23d. Date of de Month	olivery Day Year
		ysic	1 □ Yes 9 □ Uni	s 2 No	4□Pregnant at 9□Unknown	time of death	5 ☐ Other (specify) _				
S,	The law requires that the death certific that been signed by the attending p tage 2 should be detached for use as:	by Pł	Part II. Dther	significant condition	ns contributing to death b	ut not resulting in	the underlying cause g	iven in Part I.			o the cause of death?
ecoras,	require								1 Tes		robably 4 Unknown
	he law e has t ige 2 s	Completed						<del></del>	24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of
VIII H	ien: T	Be Co	25. Was case	e referred to medical				26. Place of Dea	1 ☐ Yes 2 X th (Check only one)	No 1 1 Yes	s 2 No
0 <	Physic this ce al dire	은	1 🗆 Yes	2 🗆 🗙	Hospital: 1 Inpatie		Janon G BOX		ome 5 Residence		ecify)
	nding I th. : After s funer	tlon	27. Magner o 1 Natu 2 ☐ Acci	ral 5 Pending	(Month, Da		jury Wo	ork? □Yes 2□No	200. Describe now	injury occurred	
VISION	r Atter er dea rector i by the	Certification:	3 ☐ Suic 4 ☐ Hom	ide 6 Could no	ot be 28e. Place of Inju- building, etc	ury - At home, fari c. (Specify)	m, street, factory, office	)	28f. Location (Stree City or Town,	et and Number or A State)	ural Route Number,
	To the Hospitel or Attending Physicien: The lav within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifie	Cartifying	Physician: To the best		<del></del>		and due to the caus	se(s) and manner a	s stated
	ne Hos ne Fun detely	edical	(Check one)		xaminer: On the basis of	examination and					
	To the To the comp	Σ	29b. Signatu	re and title of certifier	And American		29c Licen	se number		. Date signed (Mon	
			30. Name an	far /	tho completed cause of d	eath (Item 23a) (I	(voe Print)	> - 600		7-6-2	009
	1		SU, Martie an	1 Address of person w			18 St. B	baltimo	re MDZ	1287	
	Sta			(Month, Day, Year)	32. Registra		Soort				
	Registr	al	.)1	UL 09 200	4 tente		DOOK!				

			For State Registrar		f Marylar	_	artmen rtificat			and M		Reg. N	200	) 4	2147	2.0
	Physic		1. Decedent's Name (First, Middle, I Chaihui Michae	•							2. Date of I	Da	ay .	Year	3. Time of E	
	/Medi Examii		4a. Facility Name (If not institution, g The Johns Hopkin	rive street and nun			4b. City, Balt:		Location o	of Death	July	40	200 :. County One		17.50	
	Funeral Director		5. Social Security Number 6. 229–98–4707	Sex 157M 2□F	7. Age (In yrs. 31	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of E (Month,		- 1		lace (State or try)	Foreign
	and *		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	antion				Jan. 1	9, 1	973	Kore		
	Maryli -f sho	tor	MD Anne Ar	undel		enton	ocation							1	0d. Inside City 1 ☐ Yes	
	after death with the Marylar or Items 23e or 28e-f show	Funeral Director	10e. Street and Number 2714 Piscataway	Run Driv	e		10f. Zip 211					10g. Ci Unite		Vhat Count	try?	
980	within 72 hours after death with the Maryland ane then "naturel; or Items 23e or 28e-f show to Madical Exerciter must be multional	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For	dent Ever in U. ces? 2 A No e X		Was Deced If Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	No-	Blac	Americ k, White, o	etc.	
Maryland 21215-0036	filed withIn 72 ho Hygiene. ther then "natur int, ITS POSICS.	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education rade completed)  College (1-	-4or 5+)	16a. Dece (Give life.	kind of wor DO NOT us	rk done d	urina most	of worki	ng		and of Bu	siness/Inc	lustry	
yland 2	be file stal Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Las Sung Chul						18. Mothe Kyon		(First, Midd					
Mar	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship Concetta Cho/Wif								l Route Num					
Baltimore,	Pages 1 and 2 nent of Health ant: If item 27 I ary or other tra	. 6.	20a. Method of Disposition  **Disposition    **Disposition    **A Donation    **Donation    **Disposition    **Donation    **Disposition    **Donation    **Disposition    **Dis	☐Removal from S	C	2/14 Place of Dispo emetery, cren est Law	natory or or	ne of ther place	)	D	ate		ocation -	City or To		
Balt	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Lice	Ins-Ut	4h	41	.12 01	.d Co	lumbi	ia P:	ike E	$11i\alpha$	ce's	Fami City,	ly FH 1 MD 210	Inc.
	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List onlimmediate Cause (Final disease or condition resulting in death)	a. Metast	tatic P	ancrea	tic C	ance	r			arrest,		7	Approximate Interval Betwe Onset and Demonths	ath
	Examiner		ſ	Multip	r as a consequ le Bowe	el and	Bilia	ry O	bstr	actio	ons			7	months	3
8760,	cate be executed by sician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, reading commediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequ											
P.O. Box 68	the death certific by the attending pached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregna 9□Unknov	th 2□Fetal nt at time of de wn	death 3 = eath 5 =	Ectopic pre Other (spe	ecify)				4	23d. Date Mon	of deliver	y Day Yea	ar
ords, F	w requires that been signed should be det	by	Part II. Other significant conditions Hypotension	contributing to dea	ath but not resu	ulting in the un	iderlying ca	use giver	in Part I.			tobacco u Yes 2[			cause of deat	
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Zit V	ysicien: is certific director,	0 0	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1	patient 2 🗆 E	ER/Outpatient	: 3□ DO/				(Check only ie 5 ☐ Res		: D0th-	(Cit)		
Division of	ding Ph h. After th funeral	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month)		28b. Time of Injury		lc. Injury a Work?	at es 2 🗆 N	2	8d. Describe	how injury	y occurre	( <i>Specity)</i> d		
Divis	P die	Certification;	3 Suicide 6 Could not I 4 Homicide determined	286. Place d building	of Injury - At hor g, etc. (Specify,	)					City or To	wn, State)	,		Route Number	,
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		Σ	29b. Signature and title of certifier	in ,	0.0.	PL.D		License				29d. Date	_	(Month, Da	ay, Year)	
	6		30. Name and address of person who				•									
	Sta Registra		Paul Aoun, D.O. 31. Date filed (Month, Day, Year) JUL 0 9 2004		gistrar's Signati	0 N. W	olfe :		et B	alti	more,	MD_	2128	7		

		·	1 - For State Registrar		Maryland / [		artment of F			Reg. No.	M m 1	214	21
	Physici	an	1. Decedent's Name (First, Middle Alberta	H.	Clo	ughe	rtv		2. Date of De	Day	Year	3. Time of	Death
	/Media		4a. Facility Name (If not institution			ugne	4b. City, Town, o	Location of Dea	July	2	2004 County of Death	3:30	рм
	Examir	ler	1728 Farmingto		.,		Crofto				Anne Aru		
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last bit	rthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth		place (State ontry)	or Foreign
	Director		190-40-4873	1□M 2XXF	87	Yrs.	Working Days	Tiodis IVIII	Oct. 2			nsylva	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	m or Lo	cation					10d. Inside C	ity Limits
	Many -i ehe	ţ	MD Anne	Arundel	Croft	ton						1 🗌 Yes	
	r 28a	lrec	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Cou	ntry?	
	23a c	a	1728 Farmingto				21	114			USA		
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 ehow may highly or other traumatic event, the Wedfool Eval and martinual to rediffice and DDCs.	d by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marr 3 ☒ Widowed 4 □ Divorced	12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Date			Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🛣 No	ispanic Origin? (S In, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)	0-	14. Race - Ameri Black, White Specify: Wh	etc.	
5-0	natu	etec	15. Deceden (Specify only highes		16a	. Deced (Give	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of wo	orking	16b. Ki	nd of Business/Ir	ndustry	
121	filed within Hygiene. Ither than "	Completed	Elementary/Secondary (0-12)	College (1-4			stered Nu			Ma			
d 21	filed Hygin other ent, t	Be Cc	17. Father's Name (First, Middle,		17.0	EBTS	stered Nu		me (First, Middle		Sumame)		
<u>a</u>	And be dental rked c	To B	Albert Haag					Anna S	ullivan				
Maryland	2 should and Men Is marke aumatic		19a. Informant's Name/Relations	hip (Type, Print)	196	. Mailin	g Address (Street	and Number or R	ural Route Numb	er, City o	r Town, State, Zij	Code)	
	and ealth m 27 har tr		Gail C. Moses	(Daughter)		449	Crofton	Parkway,					
Baltimore,	Pages 1 ment of H tant: If ite jury or ot		20a. Method of Disposition  1 X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S		מופר	am P	sition (Name of natory or other place) Penn Cem.	7/7	Date /2004		cation - City or T		
Ball	permit. Departr Importa		21. Signator of Funeral Service	Lights			Name and Address Hardesty 12 Ridge	Funeral	Home, l	P.A.	, MD 21	401	
	Pnysician /Medical Examiner	_	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Due to (or	h line.	al of):	er the mode of dyin	1 7		irrest,		Approximate Interval Bette Onset and I	ween
8760,	The law requires that the death certificate be executed the sbeen signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	as a consequence								
.O. Box 6	the death certifica y the attending ph tched for use as t	Physiclan/Medical	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No 9 □ Unknown		h 2 Fetal death it at time of death		Ectopic pregnancy			2	23d. Date of deliv Month		/ear
rds, P	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant condition	ns contributing to deal	th but not resulting i	n the un	nderlying cause give	en in Part I.	23e. Did	١.	se contribute to t X No 3 ☐ Prot	he cause of d pably 4 □U	
I Records,		Completed				····			24a. Was auto perfo 1 \( \subseteq Yes		death?	ppsy findings ampletion of ca	available ause of
Vital	Phyaician: this certificanal director,	Be	25. Was case referred to medical examiner?	Hospital:			0		ath (Check only				-
of	S S	2	1 Yes 2 X No 27. Magner of Death	28a. Date of		tpatient		4   Nursing i	dome 5 A Resi		Other (Special	y)	
Division	Attending Fir death. ector: After by the funera	Certification:	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could	g (Month, gation	Day Year) I	Injury		yat k? Yes 2□No					
Divi	Dir Dir		4 Homicide determ	ined 286. Place of building	Injury - At home, fa , etc. <i>(Specify)</i>				City or To	wn, State)			ber,
	To the Hospital within 24 hours of To the Funeral I completely filled	edical	one)	g Physician: To the be Examiner: On the basi and manner	is of examination an	e, death id/or inv	estigation, in my o	oinion, death occi	e, and due to the urred at the time,	date and	place, and due to	the cause(s)	)
	To with	Σ	29b. Signature and title of certifier	ver me	0		29c. Licenso	2830			signed (Month,		/
_	15			mer, 900%	Bestgak		Print) ad #35	) Ann	apolis,	N	1/2,	140/	
	Sta Registr		31. Date filed (Month, Day, Year)	1	istrar's Signature		South						
DH	MH 17 Rev 1/2	001											

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. Na. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Vear **Physician** 50 Catherine Adele DiPaola ule 200 13 /Medical 4b. City, Town, or Location of ath 4a Facility Name (If not institution, give street and number) 4c. County of Deatl Examiner RSDE 5. Social Security Number Hours Min. Feb. 4, 1915 If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 □ F Mary Land 89 218-01-5897 Yrs. Director Usual Residence of Decedent the Marylenc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 la marked other than "natural", or Itama 23a or 28a-1 sho other traumetic event, the Medical Examiner must be notified at Bel Air Md. Harford 1 TYes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Demit. Pages 1 end 2 should be filed within 72 hours after death with Department of Heelth end Mentel Hygiane.
Important: If itam 27 is marked other than "natural", or itams 23a or any injury or other traumatic event, the Medical Examiner must be a 21014 United States 1816 Barrington Village Court Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ŽÑo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 ② No Specify: Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8 years College (1-4or 5+) hairdresser hairdressing Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Pearce Mary Baxter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catherine Sabatino/daughter 1816 Barrington Village Court, Bel Air, Md. 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gdns. 7/10/04 Timonium, Md. 22. Nama and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TIL Tes ZINO 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vaursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this After this funerel 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending s after deeth.

I Director: Aft
ad in by tha fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct complataly fillad in by 4 - Homicide edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

31. Date filed (Mo

M

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Uno

				Please	• •			Health and i	•	_	
				For State	State of Mi	•	Spartment of Certificate o			g. No.2 A A L	211.22
				Registrar  1. Decedent's Name (First, Middle, La	st)		2071,770410 0	, Dodin	2. Date of Death		3. Time of Death
_		Physici		Victor		Dangel	$\wedge$		Month	05 200	4 11:39 PM
		/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			, or Location of Death		4c. County of Dea	
				Manor Care Dulane	ey Towson	_	Towson			Baltimore	
0		Funeral		5. Social Security Number 6. S	ex 7. Ag XM 2□F	e (In yrs. last birthe	Months Day		(Month, Day,	Year) 9. Bin	thplace (State or Foreign Suntry) "Yland
nge		Director		220-05-7476	8 W 2	87 Yr	S.		Aug. 30,	1916   Mar	ryland
2		tand		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
9		Mary -f sh	ţ	MD Baltimor	e	Towson					1 ☐ Yes 2 🛣 No
1		r 28e	irec	10e. Street and Number			10f. Zip Code	ə	10	g. Citizen of What Co	ountry?
5		2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. is marked other then "natural", or Items 23a or 28e-f show aumatic event, the Medical Exams are must be redified at	Funeral Director	111 West Road			21204			USA	
Cto		lems	ner	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decedent of If Yes, specify Co	of Hispanic Origin? (Suban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
<	36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☐ <b>X</b> N	lo Specify:		Specify: wh	ite
	Ş	tural	edt	15. Decedent's E	ducation	16a. D	ecedent's Usual Occ	cupation	1	6b, Kind of Business	
	215	hin 72	piet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or :	5+)	Give kind of work dor ife. DO NOT use ret	cupation ne during most of wor ired)	king		
	21	od with	Completed	7			Electr			Self-Emp	loyed
	pu	d oth	Be	17. Father's Name (First, Middle, Last	)				ne (First, Middle, M	aiden Sumame)	
	yla	ould ?	2		'Angelo	• • • • • • • • • • • • • • • • • • • •		Adel		lagio	
	Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23e or 28e-f sho other traumatic event, The Medical Exams are must be notified a		19a. Informant's Name/Relationship (	Administr			eet and Number or Ru oad; Towso			zip Code)
		s 1 and 2 of Health item 27 i		20a, Method of Disposition	AdiiTTTSCI	20b. Place of D	Disposition (Name of	T	Control of the second	0c. Location - City or	Town, State
	Baltimore,	802 = 5		1 Burial 2 □ Cremation 3 □ □ Donation 5 □ Other (Special		1	ciematory or other p n Forest	7/13	///	)wings Mil	le MD
	altir.	permit. Pa Deparfmen Important: any injury		21. Signature (Francial Service Lice	-	Mai i i so	22. Name and Add		704	1050 Yor	
	ä	Departiment of the permitted of the perm		Tank la You	an		Ruck Tow	son Funera	1 Home	Towson,	
				23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death. Do no	t enter the mode of o	tying, such as cardiac	or respiratory arre	st,	Approximate Interval Between
4		Physician		Immediate Cause (Final disease or condition	. (	DASON	500 HA	part Fo	alare	>	Onset and Death
	4	/Medical		resulting in death)	Due to (or as	a consequence of	): 0 11	. 1	0.00		
	н	Examiner		Sequentially list conditions,	b. Due to lor as	riphe	The Vo	rscalar	Wisea	90	
		ed	Examiner	Sequentially list conditions, if any, leading to imit ediate cause. Enter Underlying Cause (Disease or injury	Due to for as	TV L	ENDE	110 50	h		
		xecut and	xan	that initiated events resulting in death) Last	c. Due to (or as	a consequence of	):	- ( - ( - ( )			
	760,	fe be executed ysician and ne burial-transit			d						
	89	death certificate b attending physical d for use as the b	by Physician/Medical								
	Box 68	h cert endin	M/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Petal death	3 □Ectopic pregna	ncv		23d. Date of de	•
		e deaf he att ed for	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a 9□Unknown		5 Other (specify)			Month	Day Year
	P.0	nat the d by ti efach	Phy	9 Unknown  Part II. Other significent conditions		out not reculting in t	ho undorking cause	given in Part I	23a Did tobs	acco use contribute to	the cause of death?
	ţs,	The law requires that the death certificate be executive has been signed by the attending physician and page 2 should be detached for use as the burial-transate.	by	Part II. Other significent conditions	continuum to death t	out not resulting in t	ne underlying cause	givoiriir aiti.			obably 4 🛣 Unknown
	Ö	r requ	Completed						24a. Was an	24h Word 2	utopsy findings available
	Rec	has ge 2	Idim						autopsy perform	ed? prior to death?	completion of cause of
	ā	in: Th	e Co	25. Was case referred to medical				26 Place of Des	1 ☐ Yes 2		2,2 No
	>	Physician: this certificanal director,	To B	examiner? 1 ☐ Yes 2 🗗 No	Hospital: 1 ☐ Inpati	ent 2 ER/Outp	atient 3 DOA			ice 6 ☐Other (Spe	cify)
	סר	ding Physician: The lav h. After this certificate has funeral director, page 2		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju	ıry 28b. Tir	ne of 28c. Ir	njury at Vork?	28d. Describe how		
	Division of Vital Records,	andin sath. or: Af he fur	Certification:	2 Accident investigation	n			☐Yes 2☐No			
	Ξ	or Att	rific	3 ☐ Suicide 6 ☐ Could not be determined	280. Place of in	jury - At home, farn tc. <i>(Specify)</i>	n, street, factory, offic	Ce	28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
		pitel ours all		29a, Certifier 12 Certifying Pl	nysicien: To the best	of my knowledge	doath agourred at the	time date and place	and due to the car	isa(s) and manner as	cetated
		24 hos Fun	edicai		miner: On the basis of and manner st	of examination and/					
		To the Hospitel or Attending Pl within 24 hours affer death. To the Funaral Director: Affer th completely filled in by the funera	Me	29b. Signature and title of certifier	1 1	0 6		ense number	_	d. Date signed (Mont	
		(		Down Att	shding!	111450	1'an /	)5364	-2 J	uly 70	7004
		211 ~	h,	30. Name and address of person who	completed cause of	death (Item 23a) (T	ype Print)	Blen	3 12	1+1	21759
	_	MA	Y	30. Name and address of person who X/ X O Z H O Y  31. Date filed (Month, Day, Year)	5601	LOCA	1-avyn	121Vd. >	10>1-tel	INNO	- /
		Sta Regist		31. Date filed (Month, Day, Year) 2004	32. Hegist	rar's Signature	The same of the sa				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 14 004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Mercy Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 1**X** M 2□ F Hours 212-34-8940 65 Director Md. July 17,1938 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State or 28a-f show the Medical Examiner must be notified at Yes 2 No N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21224 504 S. Streeper St. "natural", or items 23a Funerai 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify. þ 3 ☐ Widowed 4 X Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 Is marked other than." Elementary/Secondary (0-12) College (1-4or 5+) Union Ironworker 8 yrs. other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anna Bavota Philip Doroff Richelle – Ann Doroff

daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7528 Old Ra++10 Cross Rd 19a. Informant's Name/Relationship (Type, Print) Dundalk Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other) July 10 2004 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If it any Injury or o 1 X Burial 2 Cremation 3 Removal from State Dundalk Stanislaus Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Part 1. Enter the disease or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cereb **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician by Physician/Medicai for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Yes the be detached 9□ Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? r significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Nhknown 1 ☐ Yes 2 ☐ No page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Medicai Certification; To 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA this Date of Injury (Month, Day Year) Manner of Death 28d. Describe how injury occurred After Natural Accident Injury 5 Pending 2 No death. investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

Registrar

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

22. Registrar's Signature

21202

30. Name and address of person and completed cause of death (Item 33a) (Type, Prior

31. Date filed (Month, Day, Year)

0 9 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registra-AMEND ITEM #20b PER FH G833 Certificate of Death Reg. No... Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 8, 2004 3:45 and /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Greater Baltimore Medical Center Towson Baltimore If Under 24 Hrs. Hours | Min. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign
 Constru) **Funeral** Months Days 1**25**M 2□ F +-56-4030 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Heelth and Mental Hygiene. Industries after years with the Natylat Importent: If item 27 is marked other than "netural; or itams 23a or 28e-1 show any injury or other treumetic svent, the Medical Examinet must be notified at once. 1 Yes 2 No Completed by Funeral Director Street and Number 10f. Zip Code 10g. Citizen of What Country? 2115 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: lack 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 16b. Kind of Business/Industry 1-40r5+) Cars Elementary/Secondary (0-12) DUNSE 17. Father's Name (First, Middle, Last) Be ၟႄ 19b. Mailing Address (Street and Number or Rural Route Number, auis ( Method of Disposition 1 ■Burial 2 □ Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature : Funeral Service Lie Approximate Interval Between Onset and Death plications that caused the death. Do not enter the mode of one cause on each line. 23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Physician Cancer non-small col una /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner physiclan and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes No Month Year Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? metastases 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification; Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident after death Director: 6 ☐ Could not be 3 📋 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours a To the Funerel [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

31. Date filed Month

6701

32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		•	For State Registrar	State	of Marylar		artment of Hea			giene Reg. No.	0.01	211.26
			Decedent's Name (First, Middle	le, Last)					2. Date of Dea	ath 6	<del>-UU4-</del>	3. Time of Death
	Physici	an			D-#				July	Bay	Year 2004	1:29 A M
	/Medio Examin		Lula  4a. Fecility Name (If not institution	M. n, give street and no	Dotsor umber)	L	4b. City, Town, or Loc	cation of Death			County of Death	1 1.29 A
	Examil	eı	1800 Baffin Str				Severn				Anne Aru	nde1
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year   If I	Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day	h		olece (Stete or Foreign
	Director		276-32-0931	1□M 2\\ F	66	Yrs.	Months Days H	iours Min.	July 2			ississippi
	P .		Usual Residence of Decedent		100 0							
	arylar show	ايا	10a. State 10b. County		10c. CI	ity, Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2 🖫 No
	8a-f	ct	Maryland Anne	Arunde1			Severn					
	or 2	Dire	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28a-f show yit, the Medical Exam art must be notified at	by Funeral Director	1800 Baffin St			10 10		1144			ted Stat	
	ltems	nue	11. Marital Status	Armed F		J.S. 13.	Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (S) lexican, Puert	o Rican, etc.)	.   '	Black, White,	
36	rs aft	Ϋ́F	1 ☐ Never Married 2 ☐ Mar 3 🔯 Widowed 4 ☐ Divorced	If Yes G	: 2 [X]No Give Dates:		1 ☐ Yes 2 🎇 No S	pecify:			Specify:	lack
21215-0036	hou	edt	A	nt's Education		16a. Dece	dent's Usual Occupation	1		16b. Kir	nd of Business/Ir	
5	in 72 n° r	Completed	(Specify only highe	st grade completed		(Give	kind of work done durin DO NOT use retired)	ng most of wor	rking			,
7	iene.	E O	Elementary/Secondary (0-12) 12th	College	(1-4or 5+)	,	Volunteer				Hospita	1
D	Hyg other	Be C	17. Father's Name (First, Middle,	Last)				Mother's Nan	ne (First, Middle,	Maiden .		
au	ld be lental ked ic ev	To B	Roy	Smith				Marga	aret	В	radford	
Maryland	s 1 and 2 should be filed within 72 hours atter death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than *natural', or items 23a or 28a-f show other traumatic event, it a Medical Examinar must be notified at	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	ing Address (Street and	Number or Ru	ıral Route Numbe	r, City or	Town, State, Zij	Code)
	tealth a		Lisa M. Lyons/	Daughter	•	1800	Baffin Str	eet Se	evern, M	ary1	and 2114	44
ē,	s 1 ar		20a. Method of Disposition		20h	Place of Dispo	osition (Name of		Date	20c. Lo	cation - City or T	own, State
Ē	Page ent o nt; If ry or		1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (S		Sou	thern	matory or other place) Nevada Vete Cemetery	erans	5/2004	Pan	lder Cit	y, Nevada
Baltimore,	permit. Pages Department of H Important; If ite any injury or of		21. Signature of Funeral Service		Men	2	2. Name and Address of Oonaldson Fu	Facility	TI C (	Inn o my o	t a mer D	A Nevada
ä	Deparent Deparent Important in 2000		Vuanta &	Thomas	М00	957 1	onaldson Fu 411 Annapol	inerai Lis Roa	nome & C	on.	Marvlan	d 21113
Ġ	4.0		23a. Parti Enter the disease, o	r complications that	caused the dea	th. Do not en	ter the mode of dying, su	uch as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		shood, or heart failure. Lis Immediate Cause (Final			7	- s rrith Mot	taataai	0			Onset and Death
	/Medical		disease or condition resulting in death)	-	varian ( o (oras a c <i>on</i> se		ma with Met	Lastasi	.5			
o	Examiner											
	*	je.	Sequentially list conditions, if any, reading to immodiate cause. Enter Underlying	Dua tr	o (or as a conse	quence of):						
	death certificate be executed e attending physician and of for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events	G								
oʻ	an ar		resulting in death) Last	Due to	o (or as a conse	quence of):						
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9	rtifica ng ph as th	Jed	IEEELINE.		0000000					2.1		
Вох	eath certific attending p	an/A	IF FEMALE: 23b. Was decedent pregnant		outcome of pregn		□Ectopic pregnancy			2	3d. Date of deliv	
	deal	sicia	in the past 12 months? 1 ☐ Yes 2 🌠 No		gnant at time of		Other (specify)				Month	Day Year
P.O.	that the de led by the a detached f	hy	9 □Unknown									
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ord	w requir been si should	ted	Celebiovasc	TIAL ACCI					1 1	es 2	□No 3□Pro	bably 4 Unknown
Vital Records,	e lawr has be je 2 sh	Completed	General Deb	ility					24a. Was autop	SV	prior to co	opsy findings available ompletion of cause of
ĕ	The tate has page	E O							perfo	rmed? 2X No	death?	
ita	ician: Th certificate ector, pag	Bec	25. Was case referred to medical examiner?	ai			26	. Place of Dea	ath (Check only o			
	Physician: rthis certific ral director.	To	1 ☐ Yes 2 No	Hospital: 1	Inpatient 2	☐ ER/Outpatie	nt 3 DOA Other:	4 🗋 Nursing H	lome 🌇 Resid	lence 6	i □Other (Speci	fy)
J Of			27. Manner of Death 1 ☑ Natural 5 ☐ Pendi		e of Injury onth, Day Yeer)	28b. Time o	of 28c. Injury at Work?		28d. Describe h	now injury	occurred	
Division	Attending r death. ector: After by the fune	Certification:	2 Accident invest	tigation			M 1 ☐ Yes	2 🗆 No				
ĬŠ		ţį	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 208. Flat	ce of Injury - At h lding, etc. (Spec	nome, farm, st	reet, factory, office		28f. Location (S City or Tow			al Route Number,
Q	ital or irs afte ral Dir											
	Hosp 4 hou Fune ely fil	edical	29a. Certifier KNC ertifyi	ng Physician: To the Examiner: On the	he best of my kn basis of examin	owledge, dea ation and/or in	th occurred at the time, of	date and place on, death occu	e, and due to the our arred at the time, o	cause(s) date and	and manner as a place, and due to	stated. o the cause(s)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Ved	one)	and ma	anner stated.		29c. License nu					
	Vill To Con	Σ	29b. Signature an Vitle of certifi	91							e signed (Month,	
	$\Lambda$ .						D570	28		Ju	1y 8, 20	JU4 
	10		30. Name and address of person					221	Annapol:	ie 1	Marulana	1 21401
			Aditya Chopra		00 Ridg		enue Suite	231,	Аппарот.	то,	riar y rail(	. 41401
	Sta	ate	31. Date filed (Month, Day, Year	101 52	Registrar's Sign	L	1 .					

			1 - For Stete Registrer	State of	Maryland / De	partmer <i>ertifica</i> i				-	giene Reg. No.	2004	211.27		
	Physici		Decedent's Name (First, Middle, Last     PHYLLIS VIDA D.							Date of De Month	D	2000 Year	3. Time of Death 2:50 PM		
	/Medio Examir		4a. Facility Name (If not institution, give KESWICK NURSING					Location of			4c. C	ounty of Death			
	Funeral Director		210 60-6347	× 7. □ M 2 XF	Age (In yrs. last birtho	Months	Days	If Under Hours	24 Hrs. 8 Min.	Date of Bir Month, Da 3-9-1	f Birth  9. Birthplace (State or Foreign  County NIDAD  TRINIDAD				
	e Maryland Ba-f show	Director	Usual Residence of Decedent  10a. State 10b. County  MD • N/A		10c. City, Town o	MORE							10d. Inside City Limits 1 ∑Yes 2 ☐ No		
	th with the 23a or 2	ai Dire	10e. Street and Number 736 E. 36th ST				21218	3			10g. Citize	on of What Cou USA	intry?		
036	i within 72 hours after death with the Maryland liene. r than "natural", or flams 23a or 28a-f show the Medical Examinat must be multified at	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 [Yes 2 If Yes, Give Year or Date	es? FolNo	3. Was Dece If Yes, spe 1  Yes	cify Cuba	spanic Ori n, Mexicar Specify:	n, Puerto Ri	fy Yes or No can, etc.)		Race - Amer Black, White Specify: B			
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Maryland 21215-0036	be filed ital Hyg od othe event,	To Be Co	-12- 17. Father's Name (First, Middle, Last) CHARLES DAVIS	-0-	MU	SIC TE	ACHE	18. Mothe		First, Middle,	, Maiden S		N		
Mary	and and is m		19a. Informant's Name/Relationship (T) EVELYN MILLETT			_						Town, State, Zi			
altimore,	Pages 1 and inent of Health int: If Itam 27 iry or other tr		20a. Method of Disposition  1  8urial 2	Removal from St	20b. Place of Di	sposition (Na crematory or o	me of other plac	9)	Dat 7-13-2	e	20c. Loca	ation - City or T			
Baltii	permit. Pages Department of Important: If I any injury or once.		21. Signature Pineral Service Licens			P. Name a	nd Addres	s of Facilit	y REDI	D FUNE	RAL S	ERVICE	YLAND 21217		
	Physician /Medical Examiner		23a. Part Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. End- Due to (or	as a consequence of):	enter the mod			cardiac or r	espiratory a	rrest,		Approximate Interval Between Onset and Death Ofenry		
8760,	rate be executed objection and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of):					_					
O. Box 6	death certific e attending p ed for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birt	me of pregnancy n 2 □ Fetal death nt at time ol death n	3 □Ectopic p 5 □ Other (s <sub>i</sub>					23	d. Date of deliv	ery Day Year		
٥.	Ped Ped	þ	Part). Other significant conditions co	ntributing to deal	. 1		ause give	n in Part I.		23e. Did to			the cause of death?		
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Vita	Physician: This certificater all director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp	atient 2 ER/Outpa	tient 3 D	Othe Othe	-		Check only o 5 ☐ Resid		Other (Speci	fy)		
ion o	ding h. After fune		27. Mann Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month,	Injury 28b. Tim <i>Day Year)</i> Inju	e of 2 y M	28c. Injury Work 1 🔲 \		286	d. Describe h					
É	i Si the	Certification;	3 Suicide 6 Could not be determined	28e. Place of building	Injury - At home, farm, , etc. <i>(Specify)</i>	street, factor	y, office		281	Location (S City or Tow		Number or Run	al Route Number,		
	To the Hospital or At within 24 hours after or To tha Funaral Direct completely filled in by	edical			est of my knowledge, d is of examination and/o r stated.										
}	Vithi To the	M	29b. Signature and title of certifier  M. Gahelle VI	ac gre	ger ord		c. License	number	•			signed (Month,			
	3		30. Name and address of person who con TABBELLE THE	empleted cause	ol death (Item 23a) (Ty 700 W - 407	ne Print)									
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 0 9 2004		istrar's Signature	1-	~ .								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** July 2004 7:58 pm Eric Focht /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 261 Southeastern Terrace Baltimore Essex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 11/26/1971 32 Director 214-04-9005 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Executed must be notified at 1 ☐ Yes 2X No Director Maryland | Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code S. A.

14. Race - American Indian, 261 Southeastern Terrace 21221 death \ Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if tiem 27 is marked oth any Injury or other traumatic event Be John Kenneth Focht Nancy Fitez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 261 Southeastern Terrace Essex, Maryland 21221
ace of Disposition (Name of Date 20c. Location - City or Town, State Nancy Focht (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 7/7 2004 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Lastern Avenue Es 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or commication that caused the death shock, or heart failure. List only one cause on each line. Essex, Maryland 21221 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** newmorna /Medical Due to (or as a consequence of). ents Murcular Dystoph Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner sicien and burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physicien Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ŏ in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 📉 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 XNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide in by t 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of sertifier 2004 C. Obenovom, DOOD 7632 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. C. O'DCNOVINN, M.B., 2112 DUNDALIK AVE., BALTO MD J.C. O'DONOVAN 21222 31. Date filed (Month, Day, Year) JUL 0 9 2004 32. Pagistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryla	nd / Depa		of H	ealth a	nd Mental	Hygi	_	Jie.	2112	Q
	Dhysia		Decedent's Name (First, Middle, Last)						2. Date	of Death	10 11	Yeer	3. Time of Deal	th
	Physic /Medi		Lydia Price Fomin	aya						y 7,	2004	1001	7:15 p	М
7	Examir	ner	4a. Facility Name (If not institution, give str			4b. City, 7	Town, or	Location of	Death		4c. County	of Death		
			Hillhaven Nursing  5. Social Security Number 6. Sex		f 4 f * - t . 7		1phi		Alle		Princ		orge's	
	Funeral Director			4 0 5	88 Yrs.	If Under Months	Days	Hours		of Birth th, Day, 1	<sup>Year)</sup> 1916	9. Birthp Coun Ol	lace (State or For try) 110	aign
	filled within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-1 show int, I to Madical Examinat must be notified.		10a. State 10b. County	10c. C	ity, Town or Lo	cation					<u>.</u>	1	0d. Inside City Lin	nits
	Mar iffed	ģ	Maryland Prince Ge	orge's	Greenb	elt							1 X Yes 2 □	No
	th the	Completed by Funeral Director	10e. Street and Number			10f. Zip	Code			100	g. Citizen of W	hat Coun	itry?	
	23a	al	28 Woodland Way			1	20	0770			U.S.A	•		
	ar dez	nue		. Was Decedent Ever in L Armed Forces?	J.S. 13. V	Vas Decede Yes, speci	ent of His	spanic Origi n, Mexican,	n? (Specify Yes Puerto Rican, et	or No-	14. Race	- Americ	an Indian,	
36	s afte	Y F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give		Yes 2				,	Specify:			
9	hour tural	ed b	15. Decedent's Educa	Year or Dates:	16a. Deced	lant's Heuri	000000	tion				WILT		
15	nin 72 n "na	plet	(Specify only highest grade of	completed)	(Give	kind of worl DO NOT use	k done di e retired)	uring most o	of working	16	6b. Kind of Bus	siness/inc	dustry	
212	d withi	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	1	nasing				U	.S. Gov	vernn	nent	
b	m - 0 w	a)	17. Father's Name (First, Middle, Last)					18. Mother's	s Name (First, M	liddle, Ma	aiden Sumame	∍)		-
/lar	thould be ad Mental marked o	To B	Elbert Loren Pr	ice				Ma	ry Tha	rp				
Maryland 21215-0036	2 sh and sm		19a. Informant's Name/Relationship (Type	r, Print)					or Rural Route N			State, Zip	Code)	
≥,	1 and 1 Health em 27		Antonio Fominaya -		_				reenbelt	, MD	2077	0		
ore	of Heal		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Rer	20b. I	Place of Dispos cemetery, crem	sition (Nami	e of her place	)	Date	20	c. Location - 0	City or To	wn, State	
Ë	Pages Iment of H tant: If Ite		`4 □Donation 5 □ Other (Specify)	Met	-				/9/2004			_	Virgini	a
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	ee Hase	//				Gasch's Ave., Hy				P.A. yland 20	781
8760,	/Medical Examiner the prival transit	ical Examiner	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last	Myocardial Due to (or as a consec	Infarquence of):	tion							Approximate Interval Between Onset and Death	
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ds,	w requires that been signed b should be deta	1 by	Part II. Other significant conditions contri	buting to death but not res	uiting in the un	derlying cai	use giver	n in Part I.		1 Tyes			e cause of death?	
200	v requ been shoul	ete							_	-				
al Records,	The ate h page	e Completed							101	Was an autopsy performer 2 X	d? pri	ere autop ior to com ath? Yes	sy findings availal pletion of cause o 2 [] No	ole of
Zita Zita	Physician: this certific ral director,	O B	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No Hos	pital: 1   Inpatient 2	ER/Outpatient	2 004	Othorn		Death Check			72.5		=101
on of	ding h. After fune	$\vdash$		28a. Date of Injury (Month, Day Year)	28b. Time of Injury		c. Injury a Work?	4 X INUISI			e 6 ∐Other injury occurred			
Division	al or Attends after death	Certification:	2 Could not be	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	et, factory,	office		28f. Locat City o	ion (Stree r Town, S	et and Number State)	or Rural	Route Number,	
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	ian: To the best of my kno : On the basis of examina and manner stated.	wledge, death tion and/or inve	occurred at estigation, in	the time	, date and p nion, death	place, and due to occurred at the t	the caus	e(s) and manr and place, an	ner as sta	ited. the cause(s)	
	To t withi To tl	Σ	29b. Signature and title of centiler	)		29c.	License i	number		29d.	Date signed (	(Month, D	lay, Year)	
1			> xought	Je			D00	53337			July 9,	, 200	4	
	5		30. Name and address of person who comp Charles M. Benner,				.,#	205,	Silver S	Sprin	ng, MD	209	01	
	Sta Registr	te ar	31. Date fill (1/2001) 9. 2004	32. Registrar's Signa	ture &	sals								

			1 - State	State of Man		artment of F			2001	211.30
			Registrar  1. Decedent's Name (First, Middle, Last)			tineate or	Death	2. Date of Death	g. Ng. U U Li	3. Time of Death
	Physici		IDA VIRGINIA	FRANKLIN				JULY 2	Day Year 2004	6.30PM
7	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death	]	4c. County of Death	
			4814 LAUREL AV	/E		BALTI	MORE If Under 24 Hrs.		N/A	
	Funeral		5. Social Security Number 6. Sex	M 2DE	In yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign ntry)
	Director		214-24-9613 Usual Residence of Decedent	X	0.6 Yrs.			June 3	0,1898 но	WARD , CO
	how		10a. State 10b. County	11	0c. City, Town or Lo					10d. Inside City Limits
	Ba-1 s	Director	MD N/A		В	ALTIMOR	E			1∭XYes 2☐No
	with the	급	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
	eath	Funeral	5635 UTREC	HT RD  12. Was Decedent Eve	er in U.S. 13.1	Was Decedent of H	21206	ecify Yes or No-	USA 14. Race - Ameri	can Indian
9	s after death with the Marylan , or items 23a or 28a-f show æmitter must be notified at	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	į.		Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-1 show Acel Examitter must be notified at	d by	3 XWidowed 4 □ Divorced	If Yes, Give ** Year or Dates:		1□Yes 2火∏No	Specify:		Specify: B	LACK
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ld 2	illed I Hygi other	a l	17. Father's Name (First, Middle, Last)		110	ODDREDDI	1	e (First, Middle, M		111111111111111111111111111111111111111
ılan	o d d o	To B	WILLIAM POWELL				IDA V.	JENNIN(	ge e	
Maryland	2 should and Men Is marke sumatic		19a. Informant's Name/Relationship (Ty	•					City or Town, State, Zip	
	s 1 and f Health Item 27 other tr		BARBARA HARPER,							
Baltimore,	8° = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R			natory or other pla	ce)		Oc. Location - City or To	
Itin			* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fune All Service License	1		Name and Addre	ONAL 7-		ALTIMORE,	
Ba	permit. Departr Importa any inju		11/11/12 8	to week	X		HO		NERAL HOM	E MD 21207
	9 *		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	e death. Do not ent	er tymode of dyir	ng, such as cardiac	or respiratory arres		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	a causa on agai mia.	Caldin	Kosnic.	tou Arr	49.0		Onset and Death
1	/Medical		resulting in death)	Due to (or as a c	onsequence of):	1	P - 1	/		
1	Examiner		Sequentially list conditions,		M	ocard (a	il Iht	action		
	led sit	Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence or):	dru	A 1-60/-1	1)1500 G	<u>,</u>	
•	be executed sician and burial-transit	xar	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):	onurs 1	MICH	P13(43)		
8760,	death certificate be executed e attending physician and of for use as the burial-transit									
9	ng ph as th	Physician/Medical	IF FEMALE:							
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐		Ectopic pregnancy	/		23d. Date of delive Month	ery Day Year
0	t the dea by the a tached f	yslc	1 ☐ Yes 2 █ No 9 ☐ Unknown	4☐ Pregnant at tim 9☐ Unknown	ne of death 5	Other (specify) _			W.G.	ouy sai
9	that the		Part II. Other significant conditions con	tributing to death but n	not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	icco use contribute to the	ne cause of death?
rds	quires n sign	d by						1 ☐ Yes	2 □No 3 □ Prob	pably 4 Unknown
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Re	The law rate has be	om						autopsy performe	ed? death?	mpletion of cause of
/ita	sicien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)		
of V	S S	ို	1 ☐ Yes 2 No	,	2 ER/Outpatien		4   Nursing no	me 5 Residen		1) Stome
		ertification:	27. Manner of Death  1. Natural 5 Pending	28a. Date of Injury (Month, Day Yo	ear) 28b. Time of Injury	28c. Injur Wor	yat k? Yes 2 □ No	28d. Describe how	injumy occurred	
Division	teat feat tor: the	flcat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury	- At home, farm, stre			28f. Location (Stre	et and Number or Rura	I Route Number.
O	al or A s after I Dire	Certi	4  Homicide	building, etc. (	Specify)			City or Town,	State)	
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by		29a. Certifier  (Check only  (Check only  (Check only)  (Check only)	cian: To the best of n	ny knowledge, death	occurred at the tir	me, date and place,	and due to the cau	se(s) and manner as si	tated.
	To the H within 24 To the F complete	Medical	one)	and manner stated	1.					
	Too Con	~	29b. Signature and title of dertifier	1.0		29c. Licens	number	290	1. Date signed (Month,	Day, Year)
	- (4		30. Name and address of derson who do	ndleted cause of deat	h (Item 22a) /Tree	Print)	SON		1/0/200	7
	5		30. Name and address of gerson who do	r,MO 9	36 W	Wouth F	tue. Bu	altimos	e MO 2	1217
	Sta		31. Date file (Month, Day, Year)	32. Registrar's	Signature	4				
	Registr	ar	JUL 0 9 2004	Serlina	19 1	carles -		<del></del>		

Registrar DHMH 17 Rev 1/2001 YORK NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

2336

32. Registrar's Signature

PRASHU

31. Date filed (Month, Day, Year)

JUL 0 9 2004

JU14 5

TIMONIUM MD 21093

	Alan Pe 04-0435		Frankowski	Plea	se Type											ble.	
	MAN		For State Registrar		Sta	ite of M	arylan	-	artmei e <i>rtifica</i>				lental H	ygiei Reg.	00	11.	211.22
-	Physic	an	Decedent's Name (File		,								2. Date of I		Day	Year	3. Time of Death
	/Medi		Alan		Ρ.		Frank	cowski	Ĺ				July	03,	<sup>Day</sup> 2004	1001	1805 P <sup>M</sup>
-	Exami	ier	4a. Facility Name (If not								r Location of	of Death			4c. County	_	
			9190 Stebb 5. Social Security Number		Nay Apa			last birthda		rel or 1 Year	If Under	24 Hrs	9 Data of 5	liab	Howa		(2)
	Funeral Director		173–56–541	4	1 XM 2		45	Yrs.	Months		Hours	Min.	8. Date of E (Month, I March	28,	<sup>ar)</sup> 1959	Penn	ace (State or Foreign try) ISylvania
	Maryland -f show	tor	10a. State 10b	. County	ard		_	, Town or Laure								10	od. Inside City Limits
	with the 3c or 28a	I Direc	10e. Street and Number 9190 Stebb			Apartm			10f. Zi	p Code				_	Citizen of W		try?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health 2 is marked other than "natural", or items 23c or 28a-f show any injury or other traumatic avant, the Modical Examinat Country of political at annote.	by Funeral Director	11. Marital Status  1 Never Married 3 Widowed 4	2 Marr	12. Wa Am ed 1 [	is Decedent ned Forces? Yes 2 X es, Give ar or Dates:	Ever in U.		. Was Dece If Yes, spe	77	ispanic Ori in, Mexicar Specify:	gin? (Sp n, Puerto	ecify Yes or N Rican, etc.)		14. Race	e - America k, White, e	an Indian,
215-0036	in 72 hou	Completed	15. (Specify or Elementary/Secondary	nly highes	's Education t grade comp	leted)		(Giv	edent's Usu e kind of wo DO NOT L	ork done o	turina mos	t of work	ing	16b.	. Kind of Bu	siness/Ind	lustry
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Maryland	2 should be filed within and Mental Hygiene. Is marked othar than aumatic avant, the M.	To Be	James R.									er's Name	e (First, Midda	e, Maid <b>T</b> .	len Sumam		ternas
2	shou and M s mar		19a. Informant's Name/F	Relations	nip <i>(Type, Prii</i>	nt)		19b. Mai	ling Addres	s (Street a	and Numbe	or Aura	al Route Num	ber, City	y or Town,		
	1 and 2 Health and 27 l		James R.	Frank	owski	/ Fat		4619	Edge	mont	St.,	Phi	lade1p	hia	, PA	19137	
Saltimore	permit. Pages 1 Department of H Important: If ital any injury or ott		20a. Method of Disposition  1 Burial 2 Cre 4 Donation 5   21. Signature of Funeral	emation Other (S)	pecify)	I from State	-	lade1	osition (Na ematory or o	Crem	atori	es 7	/10/04	Ph	Location (	Inhia	Ponn
ď	permi Depa Impo any ir	,	Marat	ull	Te	MI	01113	2	614 O	na Adares	dov C	y Sla +	binski Philad	Fu	neral	Home	, Inc.
B	Physician /Medical		23a. Part1. Enter the disshock, or heart fail. Immediate Cause (Final disease or condition resulting in death)		a		the death	. Do not e	nter the mod	de of dying	g, such as	cardiac o	or respiratory	arrest,			Approximate Interval Between Onset and Death
68760.	Examiner be executed bhysician and the burial-transit	dical Examiner	Sequentially list condition and large large to immediately cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	859 :	b	due to (or as	a consecu	ianna ot)-									
O. Box	death cer e a tendin d for use	Physiclan/Medical	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1  Yes 2 No 9 Unknown		1 4	es, outcome Live birth Pregnant at Unknown	2 Fetal	death 3	□Ectopic p □ Other (sp						23d. Date Mon	of deliver	y Day Year
ords. P	w requires that the been signed by the should be detache	by	Part II. Other significant	conditio	ns contributin	g to death bu	ut not resul	Iting in the	underlying o	ause give	n in Part I.				11		cause of death?
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>	Physician: this certific ral director,	OB	examiner?	medicar	Hospital	1 🗌 Inpatie	nt 2∏E	B/Outpatie	nt 3 DC	Othe	r		<i>Ch c only</i> ne 5⊟Res		6 <b>X</b> Othei	/Canaiki	At scene
Division of	ding h. After fune	ification; T	2 Accident	Pending investig. Could n	ation ot be	Date of Injur	y Year)	28b. Time of Injury	of 2	28c. Injury Work 1 🗀 Y	at ?	10	Sed. Describe	how inj	jury occurre	se	And South Number,
Ö	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical Certification:	29a. Certifier 1□ (	Certifying Medical E	Physician: xaminer: On	To the best of	of my know examination	/ledge, dear	h occurred avestigation	at the time, in my op	e, date and inion, deat	d place, a	City or To 190 and due to the ed at the time,	Ste	(s) and man	ner as stat	26723 red the cause(s)
	To th within To th comp	Me	29b. Signature and little o	Certifier W	Lem	D			290	C. License	number				ate signed		
	10		30. Name and address of	person	no completed	cause of de				Peni	n Str	eet,	Balti	more	e, Mar	yland	d 21201
	Sta Registr		31. Date filed (Month, Oa		004	32. Registra	r's Signatu	G	Spa	ds.							
D	HMH 17 Rev 1/20	01					•		•								

		For <b>Amend Item #</b> 1 - State Registrar		Cei	titicate	e of D	eath		F	Reg. No.		211.33
Physic /Medi		1. Decedent's Name (First, Middle, Anthony	Last) Pierre Ar	Gaither	tner,	<del>.g.</del> 111		2	Date of Dea	04, Day 2004	1 <sup>Year</sup>	3. time of beath 2320P.
Exami		4a. Facility Name (If not institution, g University Hos	,			Town, or L	ocation of	Death		4c. County		1
Funeral Director		5. Social Security Number 6 214-69-2008	Sex 7. Age (	In yrs. last birthday) Yrs.	If Under Months 5	Days 21	If Under 24 Hours	Hrs. 8 Min.	Date of Birth (Month, Day 1/25/	, Year) <b>2004</b>	9. Birthp	place (State or Foreigntry)  Md.
show		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or Lo	cation							0d. Inside City Limit
ith the Ma or 28e-f s	recto	Md. NA	<u> </u>	Balti	more	Code				10g. Citizen of \	What Cour	Yes 2 N
ath with	ralDi	900 N. Bentalou				21216				USA		,
within 72 hours after death with the Maryland sne. then "naturel", or Items 23a or 28e-f show he Modical Execution in the notified at	d by Funeral Director	11. Marital Status  1    Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent Even Armed Forces?  1 □ Yes 2 X No If Yes, Give Year or Dates:	1	Vas Decede f Yes, speci I  Yes 2		panic Origir Mexican, I Specify:	n? (Speci Puerto Ri	fy Yes or No- can, etc.)	14. Rad Blad Specify	k, White,	ean Indian, etc. lack
s 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23a or 28e-1 show other traumatic event, the Modical Exactities institue notified at	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) Infant			lent's Usual kind of work DO NOT use nfant	k done dur e retired)	on ring most o	f working		16b. Kind of B	ısiness/In	dustry
1 and 2 should be filed withir Health and Mental Hygiene. tem 27 Is marked other then other traumatic event, Iha M	Be	17. Father's Name (First, Middle, La	,			1	_		First, Middle,	Maiden Suman	-/	
should be ind Mental is marked o	2	Pierre  19a. Informant's Name/Relationship	Anthony (Type, Print)	Gaith 19b. Mailin				toya or Rural F	Route Number	r, City or Town,	lill State. Zip	Code)
and 2 lealth a m 27 ls		LaToya Hill	Mother	900	N. B	enta]		t., 1	Baltimo	ore, Md	. 21	216
permit. Pages 1 am Department of Heali Important: If item 2 eny injury or other once.		20a. Method of Disposition 1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec	□Removal from State	20b. Place of Dispo cemetery, cren Voshell M	natory or oth	her place)	n 7	Dat -12-		20c. Location - Dundal		
permit. Departi Import eny inj		21. Signature of Funeral Service Lic	ensee 1	22	Name and		,	t	Ba. 1101 E	ltimore . North	, Md. Ave.	21202
Physician / Medical Examiner bulyascian and physician and physician and street bulyascian and physician street bulyascian and physician and ph	edical Examiner	23a. Part1. Enter the disease, or of shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	y one cause on each line.	nexplaine onsequence of):								Approximate Interval Between Onset and Death
	Physician/Medi	IF FEMALE: 23b. Was decedent pregnanl in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of particles of the last of the	Fetal death 3	Ectopic pred Other (spec					23d. Dati Mor	e of delive	ry Day Year
puires that n signed b	by	Part II. Other significant conditions	contributing to death but n	not resulting in the un	derlying cau	use given i	in Part I.				ibute to th	e cause of death?
ysicien: The taw requir is certificate has been si director, page 2 should	e Completed								24a. Was an autops perform	ned? p	rior to con eath?	osy findings available pletion of cause of 2 No
Physicie this certi al directo	To Be	25. Was case referred to medical examiner?   Y Yes 2 □ No	Hospital: 1 Inpatient	2 ER/Outpatient	3□ DOA	Cthor			5 Reside	e) ence 6 Othe	r (Specify	)
or Attending I ifter death. Director: After in by the funer	Certification:	27. Manner of Death  1	be Goo Bless of Injury	unknown	1 M	c. Injury at Work? 1 TYes		<b>un</b> 28f	known Location (Sti	reet and 900 b, State)	n <sup>e</sup> b	£n <b>t1\ou</b> °St
le Hospitel 24 hours a le Funerel I letely filled	Medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	Physician: To the best of mainer: On the basis of example and manner stated	amination and/or inv	occurred at estigation, in	the time, n my opini	date and p	lace, and	due to the ca at the time, da	use(s) and mar ate and place, a	ner as stand	ated. the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	heerber	1110	29c.	License ne	umber •E•		25	od. Date signed July 05	(Month, E	Day, Year) )4
		30. Name and address of person who	completed cause		Print) 3 1 1	D	n Ct-	no+	Palti	marra M	1	- 3 21201
		Tasha Zare	enses 40			Pen	ய வட	CCL,	Daren	MOTE M	<b>dr</b> vi	and 21201

	1-	For State Registrar	State o	f Marylan		artmen <i>tificat</i>					giene Reg. No.	004	21434
Physician		Decedent's Name (First, Middle, I Andrew Paul								2. Date of De Month July	Day	2004	3. Time of Death  1:40 P
/Medical xaminer	4 -	Facility Name (If not institution, g		mber)		4b. City,	Town, or	Location (	of Death	2000	4c. Cc	unty of Deetl	
xammer		Atlantic Genera	al Hospi	tal			Be	rlin			Wo	rceste	r
ineral			Sex 1DXM 2□F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De	th ey, Yeer) 195	9. Birtl	nplece (State or Foreig untry)
ector		118-70-8341	Aw 501	45	Yrs.					Jan. 9	, 195	Mar	yland
		al Residence of Decedent  State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limit
j	Ma	ryland Balti	nore			Per	ry Ho	all					1 □ Yes 2 🕅 N
Jec.	10e	. Street and Number				10f. Zip					10g. Citizer	of What Co	untry?
Q le		11-M Brook Fa	rm Ct.				21	128			u.	S.A.	
Funeral Director	11.	Marital Status	12. Was Dece Armed Fo	edent Ever in U	.S. 13.	Was Deced	lent of Hi	spanic Ori n, Mexicar	igin? (Spe	cify Yes or No Rican, etc.)	0- 14.	Race - Ame Black, White	
Т П		1 Never Married 2 Married		2 X No	-	1 🗆 Yes						ecity: (1)	lhite
yd by	-	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's		ates:	16a. Dece	dent's Hen	I Occupa	ation			16b Kind	of Business/	
lete		(Specify only highest	grade completed)		(Give	kind of wo	rk done d se retired	furing mos	t of worki	ng	100.74.10		
Completed		Elementary/Secondary (0-12) 12th Grade	College (1	1-4or 5+)	Di	spatc	her				Truc	king (	Company
Be C		Father's Name (First, Middle, La	st)					18. Moth	er's Name	(First, Middle	, Maiden Su	mame)	
To B		Paul Alvin G	088					Pa	tric	ia Anı	n Ste	vens	
	19	a. Informant's Name/Relationship								I Route Numb			
	M	Irs. Patricia A	. Goss (n	· · · · · · · · · · · · · · · · · · ·				rm Ct		erry Ho			
or other traumatic svent, the Musical Examiner must be notified at	20a	a. Method of Disposition 1 ☐ Burial 2 <b>X</b> Cremation 3	☐Removal from	State	Place of Dispo cometery, crea	natory or c	ther place			ate		ion - City or	
		4 □ Donation 5 □ Other (Spe	cify)	В	ayview								Maryland
ouce ouce	21	. Signature of Euneral Service Li	censee		22					imunek Battimo			
the burial-transit  output  the burial-transit  output  the burial-transit  the burial	Se il a call Ca tha res	sulting in death)  squentially list conditions, any, leading to immediate use. Enter Underlying uses (Disease or injury at initiated events sulting in death) Last	b. Due to	(or as a consector as	quence of):								
detached for use as the	IF 23	FEMALE: b): Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	itcome of pregn birth 2 Fett nant at time of d nown	aldeath 3	□Ectopic p □ Other (sp					230	i. Date of del Month	ivery Day Year
be d	2 7	rt II. Other significant condition	s contributing to d	leath but not res	sulting in the u	inderlying (	ause give	en in Part	1.	_	tobacco use	/	the cause of death? obably 4 Unknow
page 2 should be										24a. Was auto perf 1  Yes	ormed?	24b. Were at prior to death?	utopsy findings available completion of cause of
director, pag	D 25	. Was case referred to medical examiner?	Manatak	/			0#		e of Death	(Check only	one)		
2 D		1 √Yes 2 No Mann of Death			ER/Outpatie		-	4 U N		me 5 Res 28d. Describe			cify)
funeral	5 2	1 atural 5 Pending		of Injury oth, Day Yeer)	Injury	м .	28c. Injun Worl	k? Yes 2.⊑		200. D0301100	now injury c		
by the		2 Accident 3 Surcide 6 Could no 4 Homicide	t be 28e. Place	e of Injury - At h ling, etc. (Speci	ome, farm, st fy)						(Street and I own, State)	Number or Ru	ural Route Number,
iely fill		(Check only 2 Medical E	Physicien: To the k	pasis of examin									
	<b>U</b>	one)	and mar	nner stated.		29	c. License	e number		1	29d. Date :	signed (Mont	h, Dey, Year)
eldme	20	D. Signature and litteror certiner											
comple	29	b. Signature and title of certifier	/ MAD				053	3612	_	erlui	7/5	104	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. Nd.) Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . 2004 July **Physician** Greathouse 5, Alice Kathleen 6:45 P M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Genesis Eldercare-Heritage Baltimore Dundalk 8. Date of Birth (Month, Day, Year) July 30,1949 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□ M 2□ F 216-52-1975 54 Director Marvland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "netural", or Items 23e or 28e.4 any injury or other treumatic event, the Market and 2006. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 → No Director Essex Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21221 16 Clipper Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Agent Insurance Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Esther Dyer James O. Greathouse ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Essex, Maryland 21221 Esther Greathouse 16 Clipper Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 20a, Method of Disposition Donation 5 Other (Specify) July 9,2004 Baltimore, Maryland Oak Lawn Cemetery 21 Signature of Juneral S 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave. Essex, Md. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death 3a. Part 1. Enter the disease, or shock, or heart failure Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (95) To the Hospitel or Attending Physicien: The law requires that the death certificate be executed the attending physician Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Live birth Month Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) Yes 2 XNo 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 22 No 1 Yes 2 X No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: P 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After t 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 1/2001

State

09

2004

Division of Vital Records, P.O. Box 68760,

04-4397 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. CLEO L. GRANT Unpend Item #253427 Maryland (1893art/195) 04 Health and Mental Hygiene B.K.S Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5. 2004 **Physician** 12:15 PM JULY Tran /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CITY 3954 DOLFIELD AVENUE If Under 1 Year | If Under 24 Hrs. 9 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 XM 2□F 216-62-2125 Carolina Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location "neturel", or Items 23s or 28a-f show 1 Yes 2 □ No Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21 Funeral 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) ake Trout એ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( OCOL 19a. Informant's Name/Relationship (Type, Print) (Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 0 s. Doroth Md. 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Importent: If iter
any injury or oth 1 X Burial 2 Cremation 3 Removal from State 10/2004 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Joseph L. Russ Fr
2222 W. North Ave. Balto, Md. 23a. Part1 Enter the dilease, or complications that the sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart in ure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final Atherosclerotic Cardiovascular Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and ned for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death?

129 Yes 2 \( \subseteq \) No 24a. Was an autopsy performed? 1 Yes 2 □ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) AT SCENE Certification: To XXYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural Hospitel or Attending 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 XMedical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)
JULY 6, 2004 29b. Signature and title of certifier 29c. License number O.C.M.E

State 31. Date i

31. Date filed (Month, Day, Year)

0 9 2004

RUBIO, MO

tem 23a) (Type, Print)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

32. Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene    Department of Health and Mental Hygiene   Department of Health and Mental Hygiene   Department of Health and Mental Hygiene   Department of Health and Mental Hygiene   Department of Health and Mental Hygiene   Department of Health and Mental Hygiene   Department of Health and Health And H				1 10430	State of Ma			artmon					nione		
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The part of the County   10c Chip, Form of Location   10c Chip, County		Funeval				(In yrs. Il	ast birthday			If Under 2	24 Hrs. 8	Date of Birt	h	9. Birth	place (State or Foreign
December of December   10c. Control   10c. Contro						52		Months	Days	Hours	Min.	(Month, Day	y, Year)	Cou	ntry)
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Compared to the control of the con				shock, or heart failure. List only	one cause on each line	θ.				1305/25/2000	200	,			
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The fact intracted events of the past 12 months?    The past 12 months?   23c. If yes, outcome of pregnancy   1   1   2   2   2   2   2   2   2   2		<del>्</del>	er	Sequentially list conditions, if any, leading to immediate		consequ	uence of):			-					
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The female of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part   II.   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	ó	exectan an and rial-tr			e o (or as a	consequ	uence of):								
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.() 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 6:00 PM ARGO HOFFMAN 07 2004 04 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANORCARE WHEATON MONTGOMARY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 26,1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Days Hours Yrs. 85 206-07-6403 Pennsylvania Director Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County 77 is marked other than "netural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Montgomery Silver Spring Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910 10000 Brunswick Ave. United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Office Assistant Private Office 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 end 2 should be file Depertment of Health end Mental Hy Important: If item 27 ia marked oth any injury or other traumatic event Be Cecelia Plesko Tobias Danis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry J. Hoffman / Son 1809 Alberti Dr., Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 8 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specity) 2004 Beltsville, MD 22. Name and Address of Facility Rapp Funeral and Cremation Services 21 Signature of Funeral Service Licens 933 Gist Ave., Silver Spring, MD 20910 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 3 HONTHS Examiner Physician/Medical Examiner TPERTENSION 4 YEARS Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 ☑ Unknown 1 Tyes 2 No 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? this certificate hes 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral d 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No ne Hospitai or Attendir n 24 hours efter death. ne Funeral Director: A' pletely filled in by the ft 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) 07-07-2004 D0057630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANURADHA ARUN, MI) AVENUE STE 209 SILVER SPRING,

2004<sup>32. Register's Signature</sup>

Registrar

Division of Vital Records, P.O. Box 68760.

			1 - For State Registrar	State o	of Maryla		artment of	Health and M	, ,	giene Neg. NoO ()	0.1	
1		п	Decedent's Name (First, Middle, Last	st)					2. Date of Dea	ith CU	<del>U lļ</del> -	3. Time of Death
	Physici /Medio		CLIFFORD	HAS	KINS				JULY	8 2	Year 004	3:30 A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give	e street and nu	mber)		4b. City, Town,	or Location of Death		4c. County	of Death	
			JOSEPH RICHEY HO	SPICE			BALTI					
	Funeral		Social Security Number     6. S	ex M∑M 2∐F		. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign ntry)
	Director		212-32-6698	M SOL	68	Yrs.			MARCH .	2,1936		MD
	and wo		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits
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	death ms 2	by Funeral Director	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.		Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-	14. Rac	e - Ameri	can Indian,
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30 Am	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra		20a. Method of Disposition		1	Place of Dispo	sition (Name of natory or other pla	ace)	Date	20c. Location -	City or To	own, State
5 2	Page Page ont:		1 X Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify		AR	-	MEMORIAL		4-2004	BALTI	MORE	, MARYLAND
\$ T 20	permit. Departi Importa any inj.		21. Signature of Funeral Service Licen	see	0							S F.H., INC.
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	Physician		Immediate Cause (Final disease or condition	a Lu	ING (	CANCER						Onset and Death  Year
35	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):						- 1
0		1	Sequentially list conditions,	b. Due to	(or as a conse	quanco of):						
0	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10	(01 83 8 001136	querice or/.						
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2	eath certifica attending ph	N/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregr		Ectopic pregnanc			23d. Dat	e of delive	егу
	ie deat the att hed for	Physician/Med	in the past 12 months? 1 Yes 2 No		ant at time of		Other (specify) _	-y 		Mo	nth	Day Year
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5		by	Part II. Other significant conditions co	ontributing to d	eath but not re	sulting in the ur	iderlying cause gr	ven in Part I.		•		ne cause of death?
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Sitis	cer rect	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		750/0	Otto	26. Place of Deat				
2 6	Phys or this oral di	-	27. Manner of Death		Inpatient 2 ☐ of Injury th, Day Year)	ER/Outpatien 28b. Time of	3 ☐ DOA 28c. Inju	her: 4 \(\sum \) Nursing Ho	me 5 ∐ Reside 28d. Describe ho	ence 6 MOthe ow injury occurr	er <i>(Specif</i> ed	HOSPICE
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ffo Division	l or Attendi after death. Director: A I in by the fu	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place	of Injury - At h	nome, farm, stre	et, factory, office		28f. Location (St	reet and Numbe	er or Rura	l Route Number,
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$\bigcirc$	the H hin 24 the F	Medi	unite)	and man	ner stated.	21017 4114 01 1114						
	To To Con	-	29b. Signature and title of certifier  Megweenlum				29c. Licens	1 - 1 1 .		9d. Date signed T. 0		
	7.	1	30. Name and address of person who co	completed co	o of death (It-	m 22a) (T: 1	o yra	$nd D\phi\phi 5$	74 17	~ my	0 / 2	004
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	Registr	ar	- 001 00 700	7 /1		~ ,	copress					

			for State	State of M	aryland / De	partment of	Health and	Mental Hyg		
		R	Registrar  1. Decedent's Name (First, Middle	( ast)	C	ertificate of	Death	2. Date of Deat	eg. No [] []	3. Time of Death
	*Physic		MARY E. HI					Month	Day 6 Year	
	/Medi Examii		4a. Facility Name (If not institution,			4b. City, Town	or Location of Dea		4c. County of De	
				HOSPITAL			IMORE		N/A	
	Funeral Director		5. Social Security Number 212-03-6983 Usual Residence of Decedent	6. Sex 7. Ag 1 ☐ M 2 💢 F	91 Yrs.	y) If Under 1 Yea Months Day				rthplace (State or Foreign Country) ryland
	yland		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	e Mar te-f st	ctor	Maryland Balt	imore	Catons	ville				1 ☐ Yes 2 No
	be filed within 72 hours after death with the Maryland tal Hygiene. od othar than "natural", or tlems 23g or 28e-f show avent, I're Medical Examinations to motified at	al Director	1932 Old Frede:	rick Road		10f. Zip Code 212	228	1	0g. Citizen of What C USA	Country?
	er dea tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		3. Was Decedent of If Yes, specify Cu	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh	
920	ours afte ral', or l		1 Never Married 2 Marrie 3 Widowed 4 Divorced	od 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🛣 N	o Specify:			White
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Mai	01 02 00 00		19a. Informant's Name/Relationsh Eleanor Agnes				et and Number or R cederick		City or Town, State,	
Jre,	es 1 and 3 of Health fitam 27 rothar tra		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other pi			onsville, 20c. Location - City o	
Ë	Pages ment of ant: # its ury or o		1 ☐ Burial 2 XCremation  4 ☐ Donation 5 ☐ Other (Sp		Metro Cr	ematory.	Inc. 7/7	/04	Baltimore	e, MD
Baltimore,	permit. Pag Department Important: f any injury o		21. Signature of Funeral Service L Edward A	M		22. Name and Add Cremation	ress of Facility Society	of MD, I	nc. re, MD 212	
			23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that caused	the death. Do not e	299 Fredenter the mode of dy	rick Roading, such as cardia	d Baltimo c or respiratory arre	<del>re,</del> MD 212	
J.	Pnysician		Immediate Cause (Final disease or condition		FICULAR	TACHY	CARDIA			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					TO YEARS
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P.0	that the d ed by the detached		9 ☐ Unknown  Part II. Other significant condition		ut not resulting in the	underwing cause of	Iven in Part I	23e Did tob	acco use contribute t	o the cause of death?
Vital Records,	ed sign	ted by	HYPERTEN				TOO IN THE CALL			robably 4 Onknown
Rec	0 = 0	Completed						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
/ita	yaician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?					ath Check onl one	4	20110
ð	dis ya	5	1 ☐ Yes 2 No 27. Manner of Death	Hospital:		on color			nce 6 Other (Spe	ocify)
lon	Attending r death.	ıtlon	1 Satural 5 Pending 2 Accident investigs		ry 28b. Time y Year) Injury	W	ork? ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred	
Division	al or Attendi after death. I Diractor: A d in by the fu	ertification:	3 Suicide 6 Could not determine		ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
Ω	pital o	O	29a, Certifier 1 Certifying	Physician: To the best	of my knowledge, de	ath accurate at the	ing data and also	1		
	To the Hospital or Attending Ph within 24 hours after death. To the Funarel Diractor. After th completely filled in by the funeral	edical	(Check only 2 Medical E	xaminer: On the basis of and manner sta	t examination and/or	investigation, in my	opinion, death occi	urred at the time, da	te and place, and due	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier				ise number		d. Date signed (Moni	
	4		30 Name and address of account		A BILU I		16693	J	ULY 6,2	004
	4		30. Name and address of person w	UMD S	T. AGNE	5 HOSPI	TAL	900 CAT	ON AVE	NUE
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Rose Holmes 04-04423 RJ

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-04	423		1 - For State Registrar	State of Maryland / D	epartment of Health Certificate of Death	_	giene	
	Dhunia	, ž	Decedent's Name (First, Mittele, Las		Certificate of Death	2. Date of De		3. Time of Death
	Physic /Medi	cal	4a. Facility Name (If not institution, give	HOIMIES	4b. City, Town, or Location	July 6		04:40 A.M
	Examir	ier	Johns Hopkins Hosp		Baltimore	or Death	4c. County of Death	1
1	. Funeral Director		5 ocial Security Number 6. Security Number 11		hday) If Under 1 Year If Under 1 Year Amonths Days Hours	Min. 8. Date of Bi	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Place (Side or Foreland
,	death with the Maryland ms 23s or 28e-f ehow	tor	10a. Start 10b. Court	10c City, Jown	CIMPLE			10d. Inside City Limits 1.☐ Yes 2 ☐ No
	ith with the 23s or 28 ust be col	Funeral Director	10e. Street and Number N. CE	ENTRA/ AVE.	10f. Zip Code 2/20	2	10g, Citizen of What Co	Intry?
9600	or Ite	by	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica 1 ☐ Yes 2 ☐ M6 Specify	n, Puerto Rican, etc.)	o- 14. Race - Amer Black, White Specify:	
Maryland 21215-0036	be filed within 72 hours lal Hygiene. d other then "neturel" event, Ite Madical Ex	Completed	15. Decedent's Edi (Specify only highest grad Elementary 9econdary (0-12)		Decedent's Usual Occupation (Give kind of work done dywing mo)	ipop wouldno	HOME	ndustry
ryland		To Be (	17 Pather's Name (First, Middle Last)	tolmES	18. Worth	0.54115	HUIME	3
	is 1 and 2 should of Health and Mer item 27 is marke other treumetic		20a. Method of Disposition	5 (MITHER) 199.	Mailing Address (Street and Numb	Per or Ryal Robite Mimit HALLAND Date	Par, City of Town State, Z	Town State
Baltimore,	nit. Page artment o ortent: If injury or e.		1 ☐ Burial 2 ☐ Cremation 3 ☐ I  4 ☐ Donation 5 ☐ Other (Specify,  21. Signarde of Funeral Service, Lines	Int.	, érem - on/ or other place)  HIV HIV  22, Name and Address of Facili	7-12-04	GENDUS	UE MI.
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	Physician /Medical		23a. Part1. Ether the disease, or comp shock, of heart lailure. List only of Immediate Cause (Final disease or condition resulting in death)	pne cause on each line.  Find Stage Renal Disa.  Due to (or as a consequence o	sease	s cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
ì	Examiner	Į.	Sequentially list conditions,	b				
	cuted od ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence o	1):			
8760,	cate be executed physician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consequence o	1):			
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	sicien certifi rector	o Be	25. Was case relerred to medical examiner?  **TYPE **2	Hospital:	Diban	e of Death (Check only o		
n of		<b>—</b>	27. Manner of Death  1 Natural 5 Pending	1 ☐ Inpatient 2 ☒ ER/Outp  28a. Date of Injury (Month, Day Year) In	Datient 3L DOA 4L NE		dence 6 Other (Speci	f(y)
Division of	or Attending fter death. Director: After n by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, lari building, etc. (Specify)	M 1 Yes 2		Street and Number or Run wn, State)	al Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical Ce	29a. Certifier (Check only one)  1 Certifying Phy  **Medical Exami	rsician: To the best of my knowledge, iner: On the basis of examination and and manner stated.	death occurred at the time, date an or investigation, in my opinion, dea	nd place, and due to the atth occurred at the time,	cause(s) and manner as s date and place, and due t	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	M	29c. License number		29d. Date signed (Month, July 7, 20	
			30. Name and address of person who co	ompleted cause of death (Item 23a) (T	ype, Print) 111 Penn St	treet, Balt	imore, Maryl	and 21201
	Sta Registr	- 1	31. Date filed (Month, Day, Year)	32. Registrar's Signature				
DH	MH 17 Rev 1/2		JUL 0 9 2004	John H. Ag				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** July 4, Ruth Swan Hauver 2004 5:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homewood at Crumland Farms Frederick Frederick If Under 1 Year If Under 24 Hrs. Min. A. Date of Birth (Month, Day, Year)

Months Days Hours Min. Aug. 16, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 X F 82 1929 Pennsylvania 155-03-2008 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County 1X Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 712 Northside Drive 21701 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Supervisor of Food Service Public School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Dunham MacVean Arline Hildreth Swan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herman Albert Hauver, Jr., son 252 Winterbrook Drive, Walkersville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Moriah Cemetery 7/8/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Foxville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney and Basford Funeral Home M00999 106 East Church Street, Frederick, MD 23a. Part1. Enjet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) coVascular Disease Vears Due to (or as a consequent of) Sequentially list conditions, if any, leading to immediate the first line of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nohknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medica 26. Place of Death (Check only one) Other ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner burial-transit P.O. Box 68760, as the should be detached Division of Vital After or Attending death. after death 24 hours a within 2

MORTH

**Funeral** 

Director

or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mantal Hygiene.
and if it is a Z Is marked other than "natural", or Itams 23a or 28a.s show any or other traumatic event, I is Maricia Esan it as must be coffered at

permit. Page Department of Important: If any injury or once.

Maryland 21215-0036

Completed by Funeral Examiner Completed by Physician/Medical Be Certification: To 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D16428 30. Name an addre's person who completed cause of death (Item 23a) (Type, Print) 300 West Ninth Street, Frederick, MD Casper Cline, III, MD, 21701 De ne Hegistrar's Signature Apolls 31. Date filed (Rong. Dan frein) State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

	Registrar  1. Decedent's Name (First, Mi	iddle (act)				ertificate	UI Deal		2. Date of	Reg. No	201	14	3. Time of	Death
cian			DO3 CM	T 17					Month	Day	•	Year		
dical	LUCY L.  4a. Facility Name (If not institu					4b, City, To	wn, or Location	on of Deat	JULY h	4c.	<u>, 20</u> County		9:45P	•
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al	Social Security Number	6. Sex		7. Age (In yrs		ay) If Under 1		der 24 Hrs					place (State o	r Fore
or	218-68-8863	5	M 2. ₹	48	3 Yrs	. WOUTUIS L	Jays 110ul	3 191111.		/195			yland	
	Usual Residence of Decedent  10a, State 10b. Cou			10c. C	ity, Town o	Location						1.	10d. Inside Ci	v Lim
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Funeral Director	11. Marital Status	1	2. Was Dece	edent Ever in t	U.S. 1	3. Was Decedent If Yes, specify	nt of Hispanic	Origin? (S	Specify Yes or	No-		e - Ameri	can Indian,	
	1 Never Married 2 3 h	i	1 ☐ Yes If Yes, Giv	2 <b>X</b> No		1 Tes 2			10 1 110211, 010.)	1	Specify			
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To B	Clyde Fran	klin	Reed	1			F	ris	cilla	Gibs	on			
	19a. Informant's Name/Relati				19b. M	ailing Address (S	Street and Nur	nber or Ru	ural Route Nui	mber, City o	r Town,	State, Zip	Code)	
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		_	for State Registrar	State of Ma	aryland /				ealth a Death		R	eg. No.	00	Maria yangan	21441	ļ
П	Physicia	an	Decedent's Name (First, Middle, Last								2. Date of Dea Month	Day		ear	3. Time of Death	·
	/Medic	al	ELEANOR GERTRU  4a. Facility Name (If not institution, give		ING		4h Cih	Tour or	Location o		July	7,	2004 County of		9:22 a	IVI
	Examin	er	Laurel Regional Ho					aurel		on Doalin					rge's	
	Funeral		5. Social Security Number 6. Se	7. Ag	e (In yrs. last i	birthday)	If Unde	r 1 Year	If Under 2		8. Date of Birth	1		. Birthp	lace (State or Fore	ign
	Director		214-28-9872	M 2∏E	91	Yrs.	Months	Days	Hours	Min.	(Month, Day pril 1:	$\frac{1}{3}$ , $\frac{1}{1}$	913	Mar	yland	
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	um or l	ontio s							1	0d. Inside City Limi	4.0
	shoved	J.					Cation							1	od, inside city ∐illi 1 ☐ Yes 2 ☐ N	
	28a-f	Director	MD Howard  10e. Street and Number		Laur	ет	1 Of. Zip	Code				On Citiz	en of Wh	at Coun		_
	with Ba or	2	8477 Leishear Road					20723	₹			U.S.		at Court	.,.	
	death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13.	Was Dece	dent of Hi	spanic Orio	gin? (Spec	cify Yes or No-		4. Race -		an Indian,	
و	or Ite		1 Never Married 2 Married	Armed Forces?  1 Yes 2 1  If Yes, Give	No		n Yes, spe 1 □ Yes	-	n, Mexican Specify:	, Риепо н	sican, etc.)			White,		
Baltimore, Maryland 21215-0036	ural',	d b	3 Nidowed 4 □ Divorced	Year or Dates:									Specify:			
<u>2</u>	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23a or 28a-f show ther than "natural", or Items 23a or 28a-f show ant, I're Madical Examinat roual be nutified at	Completed by	15. Decedent's Edu (Specify only highest grad		16	(Give	dent's Usu kind of wo DO NOT u	ork done d	lurina most	of workin	g	16b. Kin	d of Busir	ness/Inc	lustry	
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מ	filed Hygi other ent.	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,					_
lan	should be nd Menfat marked c	To B	Walter D. Dorsey						Anni	ie Br	unner					
ary	2 short and h is ma		19a. Informant's Name/Relationship (7)	rpe, Print)	1:	9b. Mailir	ng Address	s (Street a	and Numbe	r or Rural	Route Number	r, City or	Town, Sta	ate, Zip	Code)	
Σ,	and and master transf	-	Joyce Souder /	Daugh					Road		rel, Ma			207		
Ore	ges 1 and 2 should be filed within 72 hours after death with the Marylan if of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event. The Madical Examiner must be nutilised at		20a. Method of Disposition  ↑ Burial 2 □ Cremation 3 □ F	lemoval from State	1	tery, crei	natory or o	other plac	1						wn, State	
Ē	tmen tant: tant:		`4 □Donation 5 □Other (Specify)		Emman	- T					10, 04		iggsv	ill	e, MD	
Ba	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		21. Signature of Funeral Service Licens	99	M00770						ome, P.		1 -		00707	
			23a. Part1. Enter the disease, or comp	ications that caused	M00770 the death. D						Laurel		ıryıa	na	20707 Approximate	
			shock, or heart failure. Listonly o												Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	a	a consequenc									4	minutes	_
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Вох	n certil anding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome		** 0.5	75-44-1					23	3d. Date o	of delive	ry	
Ö.	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 XXIVo	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			∃Ectopic p ∃ Other (s <sub>i</sub>						Month		Day Year	
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Vital Record	has l	Completed	пурст сспотоп								24a. Was a autops perfori	sy	prio	re autor ir to con ith?	osy findings availab appletion of cause of	f
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₹	Physician: The la r this certificate has aral director, page 2	To Be	examiner?	lospital: 1 ☐ Inpatie	nt 2□ER/	Outpatier	nt 3 <b>XX</b> 0	OA Othe	0.00		(Check only or e 5 ☐ Reside		□Other	(Specific	·)	
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Division of	I or Attending after death. Director: After I in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, et	ury - At home, c. (Specify)	farm, str	eet, factor	y, office		2	8f. Location (Si City or Town	treet and n, State)	Number	or Rura	Route Number,	
_	Hospita 4 hours Funeral	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exami	sicien: To the best ner: On the basis of and manner sta	examination a	ge, deat and/or in	h occurred vestigation	at the tim	ne, date and pinion, deat	d place, ar	nd due to the c d at the time, d	ause(s) a ate and p	ind mann	er as st	ated. the cause(s)	
	To the within 2 To the complet	Mec	29b. Signature and title of certifier		100		29	c. License	number		2	9d. Date	signed, (A	Month, L	Day, Year)	
	- s + 0		1 Time Ita	11/11	Who.	P	D'	D39	15	32_		71	8/1	4		
	01		30. Name and address of person who c	ompleted cause of d	eath (Item 23a	a) (Type,	Print)	/ _					70			_
	,		Timothy P. McClai	n, M.D.	321 Pr	ince	Geoi	rge S	treet	La	urel, M	aryl	and	20	707	
	Sta Registr		31. Date filed (Month, Day, Year) 0 9 2004	32. Registra	ar's Signature	de	pork									

			1 _ State	State of Maryland		artment of H			giene Reg. No. () () L	211.1.5
			Registrar  1. Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death
	Physicia /Medic		I	Mary Katherin	e Hick	S		July 6		3:15 A M
	Examin		4a. Facility Name (If not institution, give si	treet and number)		4b. City, Town, or			4c. County of D	
			6516 Baltimore A <sup>*</sup> 5. Social Security Number 6. Sex		ast hirthday)	If Under 1 Year	ında 1.k If Under 24 Hrs.	8. Date of Birtl	Balti	
	Funeral Director			M 2⊠F 73	Yrs.	Months Days	Hours Min.	Nov. 1		Birthplace (State or Foreign Country) aryland
	ס		Usual Residence of Decedent		-			1100	1100 110	-
	show	٦	10a. State 10b. County	timore 10c. Cmy	, Town or Lo	cation	D <b>u</b> nda]	l Ъ		10d. Inside City Limits 1 ☐ Yes 3√☐ No
	the M	Director	Maryland  10e. Street and Number	CIMOLE		10f. Zip Code	- Danaa		10g. Citizen of What	
	3a or			T C C C C C C C C C C C C C C C C C C C			1222		United S	
	death ms 2	by Funeral	6516 Baltimore A  11. Marital Status	Was Decedent Ever in U.S     Armed Forces?	3. 13. V	Vas Decedent of Hi Yes, specify Cubar		pecify Yes or No-		merican Indian,
9	after or Ite	/Fu	1 Never Married 2 Married	1 Yes 2 No		Tes, specify Cubar	Specify:	7 ricarr, etc.)	Specify:	White
8	hours ural',	d b	3 ☑ Widowed 4 □ Divorced	Year or Dates:	16a Dooos	lent's Usual Occupa	ution	1	16b. Kind of Busine	
5	ilied within 72 hours after death with the Maryland Hygiene. other than "natural; or Items 23a or 28a-f show ont, the Madical Evaninar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	kind of work done d DO NOT use retired,	luring most of world	king	100. Killy of Busilie	33/II/dustry
212	d with giene.	luo	Elementary/Secondary (0-12)	College (1-4or 5+)	НС	memaker			Own Hor	ne
멀	al Hyg	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
Maryland 21215-0036	ould b Ment arkac	To.	Clarence Ritteno					Myrtle F		
Mar	12 sh h and 7 is m traum	1	19a. Informant's Name/Relationship (Typ	•					r, City or Town, State Creek, VA	
	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene.  If item 27 is markad other than 'natural', or items 23a or 28a-1 show or other traumatic event, I'm Madical Examinat must be notified at		Kathryn Poole/Da 20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of		Date	20c. Location - City	
100	Pages nent of t ant: If ite ary or of		1 🔀 Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	emoval from State	-	natory or other place n Cemeter	!	204	Baltimo	re, Maryland
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau <u>2005</u> 8.		21. Signature Funeral Service License		22	. Name and Addres	s of Facility			
<u>~</u>	Per la la la la la la la la la la la la la		A regon (	- / Cescx	7	922 Wise	Ave. Du	ındalk. 1	Dundalk, Maryland 2	inc. 21222
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death e cause on each line.	. Do not ent	er the mode of dying	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician	Ø 1	Immediate Cause (Final disease or contion resulting in death)	- dyr	pha	na				7 montes
	/Medical Examiner		resulting in dealing	Due to (or as a company	ience of):					
	JA.	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	. Due to (or as a consequ	ience of):					
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9	The law requires that the death certific ate has been signed by the attending p cage 2 should be detached for use as	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregna	ncy				23d. Date of	deliven
Вох	atten af for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			Month	Day Year
P.0.	that the de led by the a detached f	hysi	9 Unknown	9 Unknown						
	res tha igned be det	by	Part II. Other significant conditions con	tributing to death but not resu	ılting in the ui	nderlying cause give	en in Part I.		,	e to the cause of death?
Vital Records,	w require been si should	Completed				<del></del>		1 🗆 Y		Probably 4 Unknown
ec	The law sate has b page 2 sh	nple						24a. Was a autop perfor	sy prior	autopsy findings available to completion of cause of
aF	ician: The certificate rector, pag							1 Yes	200 1 Y	es 22KNo
₹	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner?	ospital: 1   Inpatient 2	ER/Outpatien	t 3 DOA Othe	ar	th <i>(Check</i> on <i>ly or</i>	ne) ence 6 □Other (S	necify)
o	g Phy er this eral d	-	27. Manner of Death	28a. ate of Injury (Month, Day Year)	28b. Time of Injury	The state of the s	at	-	ow injury occurred	poonly
Ö	ttendin death. ctor: Aft y the fur	atio	1 Accident 5 Pending investigation	(1)	,,		Yes 2 □ No			
Division	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tow		Rural Route Number,
	pltal o		29a, Certifier 1 Certifying Phys	ician: To the best of my know	wledge death	occurred at the tim	e date and place	and due to the d	ause(s) and manner	as stated
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Diractor: After completely filled in by the funer	edical		ner: On the basis of examinat and manner stated.						
	To th within To th comp	Me	29b. Signature and title bi certifier	N. (1)		29c. License	number		29d. Date/signed (Mo	onth, Day, Year)
			• unc	)\(\frac{1}{2}\)		101	8487	7	7/6/6	14
	10		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)	2 (1)	CCE	BACTO	M77,77
	Y - C'	to	31. Date filed (Month, Day, Year)	32. Registrar's Signar	>N/V	11/1/60	X MA	1	15TICIO	MD 21236
	Sta Registr		JUL 0 9 2004	Beneva L	9 4	souls!				

			For State Registrar	State of Marylar		artment of H			iene	1, 211.1.0
	Physic	ian	Decedent's Name (First, Middle,	Last)				2. Date of Deat Month	h _	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution,	1+ YA //		4b. City, Town, or	Logation of Doct	Ju1y	1 200	4 11:39 a <sup>M</sup>
1	Examir	ner	930 Bay Forest			Annapo		1	Anne Ar	
	Funeral		5. Social Security Number 6	. Sex. 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	0	. Birthplace (State or Foreign Country)
	Director		Q19-12-3209 Usual Residence of Decedent	78	Yrs.			Month Day,	126	ANNÁPOLIS,MD
	Maryland e-f show	tor	10a. State 10b. County MD ANNE AF		ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 XNo
	th with the 23e or 28 ust be not	ai Dire	10e. Street and Number 930 BAY FORES	T CT		10f. Zip Code 21403		1	0g. Citizen of What USA	at Country?
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or Items 23e or 28e-1 show or other traumatic event, the Modical Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 🛣 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White etc. WHITE
15-0	n 72 h	letec	15. Decedent's (Specify only highest		(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of wor	king	16b. Kind of Busin	ness/Industry
212	iene. rthan	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 04	MANAC				BUTLDING	SUPPLIES
nd	2 should be filed withir and Mental Hygiene. is marked other than surmatic event, Ine Ms	BeC	17. Father's Name (First, Middle, La	st)			18. Mother's Nar	ne (First, Middle, M		001111111111111111111111111111111111111
Maryland	should b and Ment: marked	To	SAMUEL HYATT				IDA COHI			
Mar	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship SYLVIA WILHIDE	DAUGHTER		ng Address <i>(Street</i> a CALVERT		GREENSBC		
Baltimore,	permit. Pages 1 and: Department of Health Important: If Item 27 eny injury or other tr once.	1	20a. Method of Disposition  1X Burial 2 □ Cremation 3		Place of Dispo cemetery, crea	sition (Name of matory or other place	) 1	Date	20c. Location - Cit	ty or Town, State
ţim	Part and		' 4 □ Donation 5 □ Other (Spe	city) KNI		SRAEL CEM			ANNAPOLI	S,MD
Ba	permit. Departr Imports eny inju		21. Signature of Femeral Sovice Lie	ansag (	24	Name and Address Hardesty 12 Ridge		Home, P		21401
	Physician /Medical Examiner	J.	23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause, (Final disease or condition resulting in death)  Sequentially list conditions.	a. CUNCN R  Due to (or as a consect  b. Due to (or as a consect  Due to	quence of):	my di	such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
.O. Box 6	at the death certific by the attending p tached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet. 4 ☐ Pregnant at time of of 9 ☐ Unknown	aldeath 3	Ectopic pregnancy Other (specify)			23d. Date o Month	f delivery Day Year
S, P	res that igned b be deta	by Pł	Part II. Other significant conditions		_			23e. Did tob	acco use contribu	ite to the cause of death?
ord	w requir been si should I	eted		BRILLATION					s 2 No 3[	Probably 4 Unknown
Il Records,	: The law cate has b	Completed	HYPERCHOLEST	ENCL BMIA	AUNT	7c Asium	16 (TriTin	perform	y prio ned? dea	re autopsy findings available r to completion of cause of th? Yes 2 \( \square\) No
Vital	Physician: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2  No	Hospital:	1====	Otho		th Check onl one		
of	g Physer this eral di	n: To	27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time of	28c. Injury	at Nursing H	ome 5 Reside 28d. Describe ho	nce 6 Other ( w injury occurred	Specify)
Division	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification:	1 Natural 5 Pending investigat 3 Suicide 6 Could not determine	be 290 Bloom of Injury. At h	Injury nome, farm, str		? es 2 □No	28f. Location (Str City or Town		or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier (Check only one)  Certifying 2 Medical Ex	Physician: To the best of my kni aminer: On the basis of examina and manner stated.	owledge, death	n occurred at the time restigation, in my op	e, date and place inion, death occu	, and due to the ca rred at the time, da	use(s) and manne ite and place, and	er as stated. due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	7		29c, License			d. Date signed (A	
)	П		H.A.H			H005	66 19		7/3	1/04
	$\mathcal{O}$		30 Na and address f person wh	o completed cause of death (Itel	m 23a) (Туре,	Print)	Bork	Ste	670	NOY Ann, MD, 24
1	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature		iw NW	y 5.0		11/11/11/01/01

DHMH 17 Rev 1/200

ORIGINAL

			For State Registrar	State	of Marylar		artment of H		nd Me		giene leg. No. 1	ΩI.	21	1.1.7
			Decedent's Name (First, Middle	le, Last)					2	. Date of Dea	ith (20)		3. Tim	e of Death
	Physici /Medio		Ann	Hilt	on	H	lughes		J	Month U U	4 Day 2	OO H	3:	61 PM
1	Examir		4a. Facility Name (If not institution	-	umber)		4b. City, Town, or	Location of	Death			y of Death		
			Doctors Hospi		T	4	Lanham	If Under 24	4 Hrs. I n	Day (Dist	Princ			
١	Funeral Director		5. Social Security Number 053-28-8811	6. Sex 1 ☐ M 2 🗶 F	7. Age (In yrs.		If Under 1 Year Months Days			B. Date of Birth (Month Day May 1,	1934	Cour	olace (Stantry) aware	te or Foreign
	D .		Usual Residence of Decedent  10a, State 10b, County	,	10c C	ity, Town or Lo	cation						10d Insid	le City Limits
	lanyla show	ŏ	,	e Georges		Bowie								Yes XXNo
	28e-1	Director	10e. Street and Number	- 0001800			10f. Zip Code				10g. Citizen of	What Cou	ntry?	
	3e or		16001 Pennant	Lane			20716				USA			
36	be filed within 72 hours atter death with the Maryland ital Hyglene. id other then "naturel", or items 23e or 28e-f show event, the Medical Examinating and event, the Medical Examinating and a continuous statements.	by Funerai	11. Marital Status  1 Never Married 2XXMar  3 Widowed 4 Divorces	ried 1 Tyes			Was Decedent of H If Yes, specify Cuba 1  Yes 2 No	ispanic Origii In, Mexican, Specify:	in? (Speci Puerto Ri	ify Yes or No- can, etc.)	14. Ra Bla Speci	ice - Ameri ack, White, fy: Wh		n,
21215-0036	72 hou	Completed	15. Deceder (Specify only highe	nt's Education	1)	(Give	dent's Usual Occup	during most o	of working	,	16b. Kind of B	Business/In	dustry	
121	within ane. then "	idui	Elementary/Secondary (0-12)	College 2	(1-4or 5+)	Homen	DO NOT use retired	1)			Own H	[ome		
d 2	filed Hygie other ent, II		17. Father's Name (First, Middle,			пощеш	akei	18. Mother's	's Name (	First, Middle,	Maiden Suma			
<u>la</u> n	should be fand Mental H s marked of umatic ever	To Be	Durand Stroud					Nata	lie (	Chadwi	ck			
Maryland			19a. Informant's Name/Relations				ng Address (Street a					n, State, Zip	Code)	
	s 1 and 2 if Health item 27 i		Mark C. Hughes	s (Husban			Pennant	Lane,				0		
ore			20a. Method of Disposition 1 ☐ Burial 2 【 Cremation		m State	cemetery, crer	sition (Name of matory or other plac		Dai		20c. Location	•		е
Baltimore,	Pa nen iry		* 4 □Donation 5 □ Other (5		Me		ematory Name and Address		/7/20		Baltim	ore,	MD	
Ba	permit. Departn importe eny inju		13- J.	Cfu	•		Name and Address Hardesty 12 Ridge	Funer Ly Ave	al Ho	ome, P. Annapo	.A. olis, M	D 214	01	
			23a. Part1. Enter the disease, o shock, or heart failure. List	r compleations that t only one cause or	each line.		-		-					mate Between and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a			RESP	1847	OK	4 +	4/10/	上	1	DAY
	/Medical Examiner			Due t	o (or as a conse	quence of):	NIA						1	DAY
	p iii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due 1	o (or as a conse								1	044
_	and and II-trans	Examiner	that initiated events resulting in death) Last	c	o (or as a conse	quence of):								2/1
8760,	cate be executed physician and s the burial-transit	dicai E			HYF		ENSID	N						DAY
9	tificating phy as the													,
O. Box	The law requires that the death certiticate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live	outcome of pregr birth 2 Fet gnant at time of known	al death 3[	Ectopic pregnancy Other (specify)				1	ate of delive onth	ery Day	Year
_	quires that the name of signed by all the detaction	by	Part II. Other significant conditi	ions contributing to	death but not re	sulting in the u	nderlying cause give	en in Part I.			bacco use cor es 2□No			of death?
Records,	The law requir ate has been si page 2 should	Completed							_	24a. Was a autop: perfor	SV		mpletion	ngs available of cause of
Vital	icien: Th certificate ector, pag	Bec	25. Was case referred to medica examiner?						of Death (	Check only or	10)			
of V	Physicien: this certific ral director,	2	1 Yes 2 10			ER/Outpatier		4 🗀 14015			ence 6 □Ot ow injury occu		(y)	
	ding After fune	tion:	27. Manner of Death  1 Natural 5 Pendi	/8.4	te of Injury onth, Day Year)	28b. Time o Injury	Worl	γαι k? Yes 2∐No		d. Describe in	ow injury occu	1160		
Division	i or Attendii after death. Director: A	Certification:	2 Accident invest 3 Suicide 6 Could 4 Homicide detern	not be 28e. Pla	ce of Injury - At t Iding, etc. (Spec		reet, factory, office			f. Location (S City or Tow	treet and Num n, State)	ber or Rura	al Route I	Vumber,
	To the Hospitel or Attending within 24 hours after death, To the Funerel Director: Alter completely tilled in by the fune	Medical Co		ng Physician: To the Examiner: On the and ma										se(s)
	To the within To the compl	Me	29b. Signature and title of certific	9L	Attend	O. Phy	h. 29c. License	19	89	7	7, S	04	_	
	b		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type, ANOV	Print) PK	Luy (	GR	EEN	BELT	MI	20	2770
	Sta Regist		31. Date filed (Month, Day, Year JUL 0 9 2		Registrar's Sign	ature	Soul							

Ann Hilton Hughes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death Dav **Physician** Tsabella. 1016 AM Anna 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mercy Hospital Hospice Ctr. N/A Baltimore City If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 ☐ M 2 🖸 F 95 220-22-9179 Director 23,1909 Pennsylvania Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b County 1∩a State 28a-f show traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 ☐ No Dundalk Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21222 8128 Dundalk Avenue United States Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ☐Yes 2€ No Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 █KNo Specify: If Yes, Give Year or Dates: Specify þ 3€Widowed 4 Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Church Home Hospital Nursing Assistant 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked o Maria Theresa Guzzi Sebestiano Gerard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: if item 27 is any injury or other trauonce. Baltimore, Maryland Thomas W. Isabella/Son 5127 Viaduct Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ¥XBurial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 7/7/2004 Dundalk, Maryland <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. In not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a share the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to () as a consequence of Examiner Sequentially list conditions, if any, leading to immediate the service Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☑Other (Specify) o 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Vital Records, 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? After t Division or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospitel hin 24 hours e 12 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 2 Medical Examiner: On the basis of examiner and manner stated. within 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and odress of person no completed cause of death (Item 23a) (Type, Print) 30 106 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUL 0 9 2004

			i icas					-	Are Legible.	
			1 _ For State	State of Ma	-		of Health and	Mental Hy	giene	0111
			Registrar			ertificate	of Death		Reg. No. C U U 4	21449
т	Physici	an	Decedent's Name (First, Middle, III)					2. Date of De	eath Day Year	3. Time of Death
	/Medic		Mary Hel	en c	ones			JULY	5, 2004	4:16 PM
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120	Funeral		· ·	. Sex 7. Ag 120 M 2□F	e (In yrs. last birtho	Months	Year If Under 24 H Days Hours Mi		rth 9. Bir	thplace (State or Foreign
	Director		246 46 8110	IN ZUF	74 Yr	5.		MAY 2,	I NI	CAROLINA
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	or Location				10d Incide City Limits
	anyla sho	5			loc. Ony, rown	Location				10d. Inside City Limits
	Ba-f	Scto	MD N/A		BALTIMOR:					1 X Yes 2 No
	or 2	Dir.	10e. Street and Number			10f. Zip C	ode		10g. Citizen of What Co	ountry?
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23e or 28e-f show event, the Medical Exam are must be recilied at	Funeral Director	1221 N. LINWOOD			2121			U.S.A	
	er de	nue	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	<ol> <li>Was Deceded</li> <li>If Yes, specific</li> </ol>	nt of Hispanic Origin? y Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. Race - Ame Black, Whit	
36	s afte	by F	1 Never Married 2 Married	If Yes, Give	No.	1 Tes 2	No Specify:		Specify: D	7.7.0
21215-0036	ural,	D D	3X Widowed 4 □ Divorced	Year or Dates:					. D.	LACK
5	"nal	Completed	15. Decedent's (Specify only highest of	Education trade completed)	(0	ecedent's Usual ( Give kind of work fe. DO NOT use	done during most of w	vorking	16b. Kind of Business	/Industry
12	within ene. than	Ę	Elementary/Secondary (0·12) 6th	College (1-4or 5	5+)				FORT MEADE	PORT EXCHANG
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Ĕ		Be		>1/					, Maiden Sumame)	
7	thould b	2	JOHN STUBBS				IRENE W			
Maryland	PE a a		19a. Informant's Name/Relationship MARY D. MONTGOME!						er, City or Town, State, I	
	s 1 and 3 f Health itam 27 othar tr			(I (DAUGHTE)				-	, MARYLAND	
Baltimore,	of of		20a. Method of Disposition 1 🗡 Byrjal 2 ☐ Cremation 3	□Removal from State	cemetery,	isposition (Name crematory or othe	er place)	Date	20c. Location - City or	Town, State
<u>E</u>	Pag ment: ant: ury		*4 □ Ognation 5 □ Other (Spec	zify)	KING ME	MORIAL I	PARK JUL	Y 14. 200	4 BALTO, M	MRYLAND
alt	permit. Departr Importa any inj		21. Sounture of Funeral Service Lic	ensee / /		22. Name and	Address of Facility (	CALVIN B.	SCRUGGS FU	NERAL HOME
œ	89 5 2 9		Kellnorder	Visu	med	1412 E.	PRESTON ST	TREET BAL	TIMORE, MAR	XYLAND 21213
	30		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do not	enter the mode	of dying, such as cardi	ac or respiratory a	rrest,	Approximate
1,32	Physician		Immediate Cause (Final	y one cause on each in	И	^				Onset and Death
1	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of)	a				minute>
	Examiner			0 ( 1 . )	CO ICE	1 1 1	UCR_			10:05
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	nsit	Examiner	Cause (Disease or injury							
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×	death certificat e attending phy ed for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy					
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death	3 ☐Ectopic preg			23d. Date of del Month	Day Year
o.	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or death	5 ☐ Other (spec	rry)	-		,
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Vital Records,	w requires t been signe should be	Completed by	chanic rand	1254 B'CL		CO CO COL	back faile	4.5	<b>\</b> /	
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<u> </u>	Th ate pag	ő	prevmenia					perfo	rmed? death?	2 □ No
ta	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?		T-S(A)		26. Place of D	eath (Check only o		
	\$ .9 F	To	1 Yes 2 No	Hospital: 1 Inpatie	nt 2 EP/Outpa	tient 3 DOA	Other: 4 Nursing	Home 5 ☐ Resid	dence 6 Other (Spec	cifv)
Division of	ig Pri		27. Manner of Death	28a. Date of Injur (Month, Day		e of 28c	. Injury at Work?		now injury occurred	
0	Attending r death. sctor: After by the funer	atio	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigati		inju	M	1 ☐ Yes 2 ☐ No			
<u>Vis</u>	Atte	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place of Inju	ry · At home, farm.	street, factory, o	office	28f. Location (S	Street and Number or Ru	ral Route Number,
	al or	Sert	4 1 Horniolde	building, etc	c. (Specify)			City or Tox	vn, State)	
	Hospital 4 hours a 5 hours a Funaral i tely filled		29a. Certifier Certifying F	hysician: To the best of	of my knowledge, d	eath occurred at	the time, date and place	ce, and due to the	cause(s) and manner as	stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funaral	edical	(Check only 2 Medical Example)	aminer: On the basis of and manner sta	examination and/o	r investigation, in	my opinion, death occ	curred at the time,	date and place, and due	to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier			29c. L	icense number		29d. Date signed (Month	n, Day, Year)
•			10/10	15	rel	do	-04383		July 7	2-m4
	10		30. Name and address of person wh	completed cause of de	eath (Item 23a) /Tim			CHANI	1 3	Wiew Cive C
	10		11:11:0	Catoo	HOLE ?		MO B	الم الم	ring Ba	JUEEN Cive G
	Sta	te	31. Date filed (Wanth, Day, Year)	32 Registra	r's Signature	1 111	1)		1) 41	Ley
	Registr		JUL 0 9 200	14 Bur	a for	1	1 1			ī

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			1 - For State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death	Mental Hygie	2001 21150
	Physic -/Medi		1. Decedent's Name (First, Middle, Last, Rosalie J. Johnson			July 7	Day 2004 3. Time of Death 12:35 PM
	Examin Funeral Director	ner	5. Social Security Number 6. Sec 053-24-6805	ore Gilchrist Center	4b. City, Town, or Location of Dea TOWSON  If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Birth	4c. County of Death  Baltimore  9. Birthplace (State or Foreign County)  1923 Maryland
	iand ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	a-fsh	ctor	MD Baltimore	Towson			1 ☐ Yes 2 🛣 No
	with th	Funeral Director	10e. Street and Number		10f. Zip Code		Citizen of What Country?
	ne 23	era	1055 W. Joppa Road		21204 Was Decedent of Hispanic Origin? (9)		SA  14. Race - American Indian,
Maryland 21215-0036	d within 72 hours after death with the Maryland Jiene. r then "natural", or Itams 23a or 28a-1 show Itte Medikeal Examinat must be redified at	by	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	Amed Forces? 1 ☐ Yes 2 🛣 No	Was Decedent of Hispanic Origin? (5 f Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 【 No Specify:	to Rican, etc.)	Black, White, etc.  Specify: White
15-0	"natur	leted	15. Decedent's Edu (Specify only highest grade	completed) (Give	dent's Usual Occupation kind of work done during most of wo	rking 16b.	Kind of Business/Industry
212	f within piene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	oo NOT use retired) e Manager	Pr	ofessional
nd	Hyger t	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maid	
ryla		L <sub>o</sub>	William A. Jeffers		Bessie	Popham	
	27 Is		19a. Informant's Name/Relationship (Ty) Charles Jones /	and the second s	ig Addres <i>s (Street and Number or R.</i>		y or Town, State, Zip Code) altimore, MD 21202
Baltimore,	Pages 1 and neut of Heat Int. If itam Irry or othe		20a. Method of Disposition  1 Burial 2 Termation 3 B  4 Donation 5 Other (Specify)	20b. Place of Dispo	sition (Name of natory or other place) ervice Corp. 7/1	Date 20c.	Location - City or Town, State
Balti	permit. Pages Department of I Important: If iti any injury or or once.		21. Signature of Fu erell Service Ligense	22	Name and Address of Facility ICK Towson Funera		1050 York Road Towson, MD 21204
1	Physician		Immediate Cause (Final	cations hat caused the death. Do not ente e cause on each line.	er the mode of dying, such as cardia.		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of):	Chricek		months
	Examinei	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events	200 (0, 20 2 00.100400100 01).			
68760,	Ifficate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a consequence of):			
_	ortificate ing phy a as the	Medicai	IF FEMALE:				
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Vital Records, P.	quires that t n signed by uld be detai	by	Part II. Other significant conditions con	tributing to death but not resulting in the un	derlying cause given in Part I.		o use contribute to the cause of death?
eco	e faw requir has been s ge 2 should	Completed				24a. Was an	24b. Were autopsy findings available
<u> </u>		Con				autopsy performed? 1 ☐ Yes 2 2 N	prior to completion of cause of death?  1 □ Yes 2 □ No
	ysician: The is certificate hadirector, page	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 No	ospital:	Other	th (Check only one)	~
ס ר		$\vdash \vdash$	27. Manner of Death	28a. Date of Injury (Month, Day Year)  2 ☐ ER/Outpatient 28b. Time of Injury	3 DOA 4 Nursing H 28c. Injury at Work?	ome 5 Residence 28d. Describe how inju	
Division of	Attending Physician: It death. actor: After this certific by the funeral director.	catic	1 ANatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No		
Σ	Dic	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)		City or Town, Star	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin	ician: To the best of my knowledge, death er: On the basis of examination and/or invi- and manner stated.	occurred at the time, date and place estigation, in my opinion, death occu	, and due to the cause( rred at the time, date ar	s) and manner as stated.  nd place, and due to the cause(s)
	Vithin To th Comp	We w	29b. Signature and title of certifier	1-0	29c. License number		ate signed (Month, Day, Year)
	0		· Coll. Hollo	my Killey, mo	D25205	5	(y 7, 200x
١	(V'(')		30. Name and address of person who cor	npl ted cause of de-h tem 23a) (Type, P GBMCV6701	V. Charles St.	Bulto. n	nd 2120x
	Sta Registra	-	31. Date filed (Month, Day, Year)	d2. Registrar's Signature	V		

			1 - For State Registrar	State of Maryla		artment of I rtificate of		Menta		0001	0.1.
	Physic /Medi		Decedent's Name (First, Middle, Las     ROOSEVELT	JOHNSON		· imodio or	Douth		Reg. No of Death		3. Time of Deat 2: 05 F
	Exami		4a. Facility Name (If not institution, give Saint Joseph	street and number) Medical Ce	enter	4b. City, Town, o	or Location of De	eath V S O Ti	4	c. County of [	gent imore
	Funeral Director		5. Social Security Number  218-01-9764  Usual Residence of Decedent	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Mor	of Birth oth, Day, Yea	9.07	Birthplace (State or Fore Country) VIRGINIA
Maryland	f show	ō	10a. State 10b. County	10c.	City, Town or Lo		DD GT	137			10d. Inside City Lim
with the h	e or 28a- Le rotif	Direct	MD N/A  10e. Street and Number	STREET		BALTIMO 10f. Zip Code 212		Υ Υ	10g. C	itizen of Wha	21
72 hours after death with the Maryland	iene. rthen "netural", or Items 23e or 28a-f show It e Medical Examinar must be rediffed at	y Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces?  15. Yes 2 No		Was Decedent of H	dispanic Origin?	(Specify Yes erto Rican, et	or No-	14. Race - A Black, V	American Indian, Vhite, etc.
ad within 72 hours aft	e. an "netural" Medical Ex	Completed by	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's Ed (Specify only highest grav  Elementary/Secondary (0-12)	Year or Dates:	16a. Decec (Give life. I	dent's Usual Occup kind of work done OO NOT use retire	pation during most of w	orking		Kind of Busine	,
be file	the int,	Be	7 years  17. Father's Name (First, Middle, Last)		F'1	SHERMAN	18. Mother's N		fiddle, Maide	SEAMAN n Sumame)	· · · · · · · · · · · · · · · · · · ·
shoutd		10	JERRY JOHNSON  19a. Informant's Name/Relationship (7)		19b. Mailin	g Address (Street	ADD and Number or		arter	or Town. Stat	te. Zip Code)
es 1 ar	of Health item 27 r other tr		IRENE SHELTON 20a. Method of Disposition 1 1 Cremation 3 1		2325	GUILFO	ORD AVE		BALTI	MORE,	MD 21218 or Town, State
permit. Pages 1 a	Department Important: If eny injury or once.		* 4 □ Donation 5 □ Other (Specify,  21. Signature Funeral Service Licens	G	22	Fores	ss of Facility H		FUNE	ERAL H	
200	ysician		23a. Payl 1. Enter the diffease, or comp shock, or heart failure. List only of Immediat—ause (Final disea—r condition	lications that caused the de ne cause on each line.	n. Do not ente	00 LIBE or the mode of dyin				ALTIMO	Approximate Interval Between Onset and Death
	Medical buyand and physician and sthe burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Extended the first cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.	equence of):						
The law requires that the death certificat	igned by the attending phy be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 🗌	Ectopic pregnancy Other (specify)				23d. Date of o	delivery Day Year
quires that	been signed be should be det	by	Part II. Other significant conditions co.	ntributing to death but not re	sulting in the un	derlying cause give	en in Part I.				to the cause of death?  Probably 4 □Unknow
	has le 2	Completed							Was an autopsy performed?	prior t death	
ysicier	is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ▼ No	lospital:	BER/Outpatient	3□ DOA Othe	26. Place of De		CHECK THE	6 ☐Other (S <sub>I</sub>	necifu)
Attending Physicien:	atter death.  Director: After thi in by the funeral		27. Manner of Death  1/☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work			ribe how inju		Jaciny)
ital or Att	within 24 hours after of To the Funerel Direct completely filled in by t	Certification	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	:ify)			City of	r Iown, State	)	Rural Route Number,
he Hosp	within 24 hou To the Fune completely fi	edical	29a. Certifier (Check only one)  1 Certifying Physical Certifying Physical Examination (Check only one)	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death nation and/or inve	occurred at the time estigation, in my op	e, date and plac pinion, death occ	e, and due to urred at the ti	the cause(s)	and manner place, and d	as stated. ue to the cause(s)
Tot		×	29b. Signature and title of centifier	ulta mic	)	29c. License	number 41410		29d. Dat	te signed (Mon	nth, Day, Year)
	2		30. Name and address of person who co	EHTA M. D.	7601 0	rint) DSLER DI	RIVE_TO	WSON,	, MAR	YLAND	21204
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	4 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 4a. Facility Name (If not institution, give street and number) 6:00P 2004. /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Mari If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) BALTIMORE 7. Age (In yrs last birthday) Birthplace (State or Foreign Country) **Funeral** 1**2** M 2□F Director lanc Usual Residence of Decedent 10a. State 10c. City, Town or Location ortant: If item 27 is marked other than "naturel", or itema 23a or 28a-1 ehow injury or other traumatic event, the Medical Examinar Funsi be notified at 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234. jill ough lo 12. Was Decedent Ever in U.S. Amed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1a ineer Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Department of Health and Mental. Important: If item 27 Is marked o Pages 1 and 2 should be FRANK 19a. Informant's Name/Relationship (Type, rint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore 2806 willoughby Knapik-wite Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dulancy Valley Meny Gar: 1-12-04 Timonium mi 22. Name and Address of Facility BALTIMORE, MD 21234. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice any in EVANSFUNERAL CHAPEL, 8800 HARFORD RD 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 48-1/156 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Lary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal dea

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been ALCOTIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has CETESTE VISCOLET Division of Vital 1 ☐ Yes 2/2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient within 24 hours after death. To the Funeral Director: After this 3□ DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM MD21093

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JUL 0 9 2004

JOSEPH KNAPIK

32. Registrar's Signature

		•	FUI	epartment of Health and Mental Certificate of Death	Hygiene
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Month	of Death Day Year.
	/Medic Examir	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	7 2004 1a:30 A, M
1			Gilchrist Center	Towson  If Under 1 Year   If Under 24 Hrs.   8, Date of	BALTIMORE  A Birthplace (State or Greener
ı	Funeral Director		5. Social Security Number  6. Sex 1 M 20 F  7. Age (In yrs. last birth.	Months Days Hours Min. (Monti	of Birth h, Day, Year) 9. Birthplace (State or Foreign Country) 22-1918: WAR YLAND
	yland		Usual Residence of Decedent 1  10a. State 10b. County 10c. City, Town (	or Location	10d. Inside City Limits
	with the Maryland to or 28a-f show Le notified ut	ector	MD BALTIMORE ?	SALTIMORE 101. Zip Code	1 ☐ Yes 2 No
	th with 23e or	ai Dir	71 Dendron Ct	21234	USA
10	fler death	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married   1 Yes 2 No	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol>	or No- 14. Race - American Indian, Black, White, etc.
5-0036	hours after tural', or its al Evandre	ρ	3 Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 1 No Specify:	Specify: White
215-	"na	Completed	(Specify only highest grade completed) (6	lecadent's Usual Occupation  Give kind of work done during most of working  ife. DO NOT use retired)	16b. Kind of Business/Industry
2	filed wi Hygien other th		17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mi	Kile Aid iddle, Maiden Sumame)
yland	2 should be filed withir and Mental Hygiene. is marked other than aumatic avent, the Mi	To Be	Harlan Hoover	Julia A.	Smith
Maryl	and 2 sh eelth and m 27 is m		19a. Informant's Name/Relationship (Type, Print)  19b. Name/Relationship (Type, Print)  19b. Name/Relationship (Type, Print)	Aailing Address (Street and Number or Rural Route N	
ore,			20a. Negthod of Disposition 20b. Place of Disposition 3 Demonstrate commetery.	Date crematory or other place)	2 c. Location - City or Town, State
altimore	permit, Page Department Importent: if any injury o		*4 ☐Donation 5 ☐Other (Specify)	Palley Men Condens 7-10-0	Timonium mo 21234
B	Depo Impo any		Kindrely a switzy	22. Name and Address of Facility RD., 7 2325 YOUR RD., 7 POALEFUL ALTERNATIVES	FUNGRAL + CILIMATION OTR
	Physician		23a. P. rt1. Enter the disease or complications that caused he leath. Do no shock, or heart failure. Jist only one diuse on carr line.  Immediate Caus. Final disease or condition.	The The rive	Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)  a	1 - /-	mmolis
		ner	Sequentially list conditions, largy scaling immediate cause. Enter Underlying	Cron a ce	gesis
	and and Il-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of)	c obstructue les	ny disense your
8760	ate be executed hysicien and the burial-transit	dicai E	d		
Box 6	leath certificate ettending phys i for use as the	0	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 ☐ Ectopic pregnancy	23d. Date of delivery
P.O. B	the death y the etter iched for u	Physician/M	in the past 12 months? 1  Yes 2 No 9 Unknown	5 Other (specify)	Month Day Year
	w requires that the de been signed by the s should be detached	by Pł	Part II. Other significant conditions contributing to death but not resulting in the	and and and and and and and and and and	Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ 46 3 ☐ Probably 4 ☐ Unknown
cord	taw requi	Completed by	Acrtic VALVE VEPLA	ce mend 24a.	Was an 24b. Were autopsy findings available
Vital Records,	siclen: The taw s certificate has t lirector, page 2 s				autopsy prior to completion of cause of death?  yes 2 No 1 □ Yes 2 □ No
	ysiclan is certif director	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outp	26. Place of Death (Check of attent 3 DOA Other: 4 Nursing Home 5	
on of	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28b. Tim (Month, Day Year)	ne of 28c. Injury at 28d. Description	ribe how injury occurred
Division	r Attenter ter deat irector:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined building, etc. (Specify)		ion (Street and Number or Rural Route Number, r Town, State)
Ω	To the Hospitel or Attending Physicien: The twithin 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	al Cel	29a. Certifier 12 Certifying Physician: To the best of my knowledge, or	death occurred at the time, date and place, and due to	the cause(s) and manner as stated.
	thin 24 I	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier	or investigation, in my opinion, death occurred at the ti	29d. Date signed (Month, Day, Year)
	₽ ¥ ₽ 8		> If Anthy Rily, in		
	N		30. Name and address of person who completed cause of death (Item 23a) (Ty	10 D25205 101 N. Chule St.	Bulto Md 21204
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	, , ,	
	Registi	ar	JUL 0 9 2004 Benever 19	loads!	

Many Birwan expire 7-7-64 @ 12:30 Am

Please Type or Print In Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U U 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Month Dev Year elores Kennedy JUL 2004 /Medical 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner 4b. City, Town, or Location of Deeth 38 N/A Koad Baltimore If Under 24 Hrs. 8. Da YNNE 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Year Birthplaca (State or Foreign Country) **Funeral** Days 1□M 200/F 219 - 74-8070 Usuel Residence of Decedent - 74-8020 Director Yrs. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or itema 23a or 28a-1 show any fujury or other traumatic event, the Medical Exantmet must be northed at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MM 1 1 No Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 38 USA 39 212 nne 12. Wes Decedent Ever in U,S Armed Forces? 11. Meritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 No To Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12t iec 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary homas COUPER 19a. Informant's Neme/Relationship (Type, Print) . 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Baltimo ne Bessie Road mo 21239 6138 E 20b. Placa of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Duriel 2 □ Cremation 3 □ Removal from State Baltimone County, MD 8 memorial 4 ☐ Donetion 5 ☐ Other (Specify) 104 21. Signature of Funeral Servica License 22. Name,and Address unera vervice, P. fari Bultimone 2120 Tessien 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) Bladder Carringua Examiner Due to (or as a consequence of): Physician/Medical Examiner ate has been signed by the attending physician and page 2 should be detached for usa as the bunal-transit To the Hospital or Attending Physician: The law requiras that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probabty 4 ☐ Unknown 1 ☐ Yes 2 ☐ No edical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? within 24 hours after death.

To the Funeral Director: Aftar this cartificate has I completely filled in by the funeral director, page 2 is 1 Tes 2 X No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE 27. Menner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Cedifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name end eddress of person deeth (Item 23a) (Type, Print) ulen

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

JUL 0 9 2004

32, Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July **Physician** 7, 5:00 a M 2004 Florence Grace Krug /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11805 Chantilly Lane Mitchellville Prince George's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year, Jan. 31, 1 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months 1906 98 Georgia Director 579-14-6575 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 77 is marked other then "neturel", or items 23e or 28e-1 show treumatic event, the Medical Example, must be inclided at 1 ☐ Yes 2X No Director Prince George's Mitchellville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20716 11805 Chantilly Lane U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be filment of Health and Mental Hient: If item 27 is marked ot Grace Elinor Boland Joseph Dennis Hearn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11805 Chantilly Lane, Mitchellville, MD 20716 Evelyn L. Hannum - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 permit. Page Department of Importent: If any njury or once. 7/12/2004 Fort Lincoln Cemetery Brentwood, Maryland 1 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Ave., Hyattaville, MD 20781 Constance 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final myocard **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, trauling to infine diate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown the detached s been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Paget's disease of bone with chronic parts. 23e. Did tobacco use contribute to the cause of death? with chronic pain 1 Tes 2 No 3 🗌 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy Colon cancer reserved 1981, Nonagenarian cerificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 🗌 Yes 5 Residence 6 Other (Specify) ို 2 No this After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation s after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as autoc.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ghway #204 miles

State Registrar

31. Date filed (Month

DHMH 17 Rev 1/2001

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed

P.0.

Division of Vital Records,

or Attending Physici n:

death.

37. Registrar's Signature

				State of Maryland / Department				•				
			1 - For State Registrar	Cei	rtificate of	Death	Reg.		211.56			
ı	Physici /Medic		1. Decedent's Name <i>(First, Middle,</i> La: Mikell Knights Al				2. Date of Death Month June 24, 2	Day Year 2004	8:00p M			
	Examir		4a. Facility Name (If not institution, give	e street and number)		or Location of Death		4c. County of Death				
		*	Stella Maris Nurs 5. Social Security Number 6. S		Timonii		B. Date of Birth	Baltimore				
	Funeral Director		051-32-1413	MM 2 F 64 Yrs.	Months Days	Hours Min.	July 23	, 1939 Coul	place (State or Foreign ntry) NY			
	Maryland a-f ehow	tor	10a. State 10b. County	Baltimore 10c. City, Town or Lo		s Mills			10d. Inside City Limits 1 ☐ Yes 2 📉 o			
	th with the 23a or 28a	al Director	10e. Street and Number 9412 Owings Hts	Cir, Apt 104	10f. Zip Code	21117	10g.	Citizen of What Cou USA	ntry?			
215-0036	J within 72 hours after death with the Maryland jiene. Jiene. The Medical Evacione must be notified at	by Funeral	11. Marital Status  1 Never Married XX Married 3 Widowed 4 Divorced	1 TYPES 2 TNO OTHER	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spec an, Mexican, Puerto R Specify:	fy Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: Bla	etc.			
<u>2</u>	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	de completed) (Give	dent's Usual Occup kind of work done	during most of working	166	. Kind of Business/In	dustry			
2	filed within Hygiene. other than "	дшо	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retire Station	Supervisor	1	City T	ransit			
	be filed stal Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last) Mikell Knigl			18. Mother's Name (	First, Middle, Maid La Allen					
	nd 2 sh alth and 27 is m r traum	-	19a. Informant's Name/Relationship ( Faridah Abdul 1			and Number or Rural S Hts Cir,						
altimore,	Se to to		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ♣  4 ☐ Donation 5 ☐ Other (Specification)	Hemoval from State	natory or other pla	Cemetery July	202	Location - City or To				
Balti	permit. Page Department ( important: if any injury or once.		21. Signature of Funeral Service Licer	Tom Zizos 22	2. Name and Addre		Funeral	Home Inc.				
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	neations that caused the death. Do not ent					Approximate Interval Between Onset and Death			
/60,	e be executed /sician and e burial-transit	cal Examiner										
O. Box 68	death certificat e attending phy od for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnanc	у		23d. Date of delive Month	ery Day Year			
ds, P	luires that the de signed by the a lid be detached f	by	Part II. Other significant conditions of	ontributing to death but not resulting in the u	nderlying cause gr	ven in Part I.		co use contribute to the	ne cause of death?			
Hecords,	The law requires that the sate has been signed by the page 2 should be detache	completed					24a. Was an autopsy performed	prior to condeath?	psy findings available mpletion of cause of 2 No			
Vital H	il <b>cian:</b> Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	Mary Ard	0.1	26. Place of Death (	Check only one)					
0	Physic this c	2 ·	1 ☐ Yes 2 ▼ No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien  28a. Date of Injury 28b. Time of	It 3 DOA	The second secon	5 Residence	6 Other (Specification)	/)			
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Division	il or Atten after deat Director: d in by the	ertification:	3 Suicide 6 Could not by determined				f. Location (Street City or Town, St	and Number or Rura ate)	I Route Number,			
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical C	29a. Certifier (Check only one)  Certifying Ph	ysician: To the best of my knowledge, death niner: On the basis of examination and/or in and manner stated.	n occurred at the ti vestigation, in my o	me, date and place, an opinion, death occurred	d due to the cause at the time, date	e(s) and manner as stand place, and due to	ated. the cause(s)			
)	To the within To the comp	Me	29b. Signature and title of certifier		29c. Licens	se number	29d.	Date signed (Month,	Day, Year)			
	1		30. Name and address of person who	completed cause of death (Item 23a) (Type,	Print)							
			DR. TARIQ MAHMO 31. Date filed (Month, Day, Year)	OD 2300 DULANEY VAL  32. Registrar's Signature			MD 21093	3				
	Sta		.IIII 0 9 200		Som K							

DHMH 17 Rev 1/2001

8:00 р.т.

JUNE 24, 2004

MIKELL ABDUL-LATIF

			1 - State	State of Ma	aryland		irtment of F			, ,	00	101	011 [
			Registrar  1. Decedent's Name (First, Middle, Las	st)		Cei	uncate or	Dealii		2. Date of Dea	Reg. No.	104	3. Time of Death
	Physici			Loe11	Mar	tens				June 2	Day	Year	22:45 M
	/Medio Examin		4a. Facility Name (If not institution, give		1 10.1	Cens	4b. City, Town, o	r Location (	of Death	oune z		unty of Death	22.43
	EXAMIN	er	Calvert Memoria				Prince					lvert	
	Funeral		5. Social Security Number 6. Se	ex 7. Age		st birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birth	Vonel	9. Birth	place (State or Foreign
ı	Director		504-22-7552	<b>⊠</b> M 2□F	73	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day May 26	1931	Соці	ntry)
	Du		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	ration						Od. Inside City Limits
	laryla shor	o.	SD Minnehah	าล		Sioux							1 X Yes 2 □ No
	28a-1	ect	10e, Street and Number				10f. Zip Code				10a Citizer	of What Cou	
	3a or	Funeral Director	312 South Mable	Avenue			57103	3			USA	· · · · · · · · · · · · · · · · · · ·	,
	death ms 2:	era	11. Marital Status	12. Was Decedent I	Ever in U.S	i. 13. y	Vas Decedent of H Yes, specify Cuba		gin? (Spe	cify Yes or No-		Race - Americ	
9	or Ita	Fū	1 ☐ Never Married 2 Married	Armed Forces?  1 MYes 2 N If Yes, Give	No		Yes, specify Cuba	an, Mexicar Specify:		Rican, etc.)		Black, White, ecify: Whi	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show re Modical Examirer must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			1 165 2 <b>2 25</b> 110	зреспу.			Sp	еслу: Мітт	
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d 2	filled Hygin ther ant,		12 17. Father's Name (First, Middle, Last)						er's Name	(First, Middle,	Maiden Su	mame)	
an	ld be ental kad c	To Be	James A. Marter	ıs				Alio	da E.	Fields	3		
Maryland	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, If a Medical Examinar must be notified all ODGs.		19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailin	g Address (Street	and Numbe	er or Rura	/ Route Number	r, City or To	own, State, Zip	Code)
Σ	and 2 salth a n 27 is		Sheila Olson / I	Daughter			Sollers V	Marf	Road	l Lusby	MD	20657	
altimore,	of He		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Pla	netery, crem	sition (Name of hatory or other place Rest Memo	:е)				ion - City or To	
Ē	Pag ment tant; jury c		* 4 ☐ Donation 5 ☐ Other (Specify	()	HII	Pai	ck			1104	Siow	Falls	, SD
Ball	Sermit Separ mpor my in		21. Signature on Funeral Service Licen	See .		Ch	Name and Addre	Ste	<i>i</i> ens	Funera1	. Home	e Inc.	
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	Pnysician /Medical		disease or condition resulting in death)	aDue to (or as	2 CODE POU	-	cardial		star	chen			
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9 X	certifi ding	/Me	IF FEMALE:	23c. If yes, outcome	of pregnan	icv					224	. Date of delive	
Вох	that the death certificed by the attending to detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic pregnancy Other (specify)				230.	Month	Day Year
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ď.	The law requires that the tee bas been signed by the base been signed by the bage 2 should be detache	by P	Part II. Other significant conditions of	ontributing to death be	ut not resul	ting in the un	derlying cause give	en in Part I.		23e. Did to	bacco use	contribute to the	e cause of death?
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ecc	e law r has be je 2 sh	Completed								24a. Was a autops	n 2	4b. Were auto	psy findings available appletion of cause of
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of	Physician: r this certific ral director,	T0	Yes 2 No 27. Manper of Death	Hospital: 1 ☐ Inpatie		R/Outpatient		4 🗀 NU		ne 5 Reside			1)
uo	ding I	tlon	1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		28b. Time of Injury	28c. Injun Worl	γαι k? Yes 2 ⊡i		8d. Describe ho	ow injury oc	currea	
Division	l or Attending after death. Diractor: After in by the fune	fica	3 Suicide 6 Could not be		ury - At hon	ne, farm, stre				8f. Location (St	reet and N	umber or Rura	f Route Number,
<u>S</u>	al or A after I Dira	Certification;	4  Homicide	building, etc						City or Towr	n, State)		
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Ph	ysician: To the best of	of my know	ledge, death	occurred at the time	ne, date an	d place, a	nd due to the ca	ause(s) and	manner as si	ated.
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	To To	∑ .	295. Signature and title of certified	1 11			29c. Licensi	e number		2	9d. Date si	gned (Month,	Day, Year)
7	A		TayVV	240	/		Dit	32	1_		6/20	7/04	
	19	~	30. Name and address of person who d	completed cause of de	eath (Item :	zda) (Type, F	"(Int) 32 ,	COX	1	stag		GM	20639
	Sta	te	31. Date filed (April Daf ) Pari 200	32 Registra	ar's Signati	Ire /	1	w	buc	Lom	74)	1	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Vear **Physician** Markiewicz 2:30AM ames 2004 July /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 429 Drew Street Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 18 M 2□F 75 Yrs. Director 220-20-0574 Feb 24, 1929 Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylend Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28s-1 ehow any Injury or other traumatic event, the Medical Examinat must be notified at DDCs. 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 429 Drew Street 21224 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: Completed by Year or Dates: 1966-47 3 ☐ Widowed 4 ☐ Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Transportation Elementary/Secondary (0-12) College (1-4or 5+) Taxicab Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be James M. Markiewicz Anna Koch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Virginia Markiewicz/Wife 429 Drew Street, Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Buria! 2 ☑ Cremation 3 ☐ Removal from State Jul 9 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Chesapeake Crematory 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility M50986 Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) · Chronic Obstructive Pulmonary Disease /Medical ears Examiner Examiner es the bunal-trensit or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physicien and Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 □ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? is cartificate has been si director, paga 2 should 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No Aftar this cartificate funeral director, pag 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 2 No Certification: To 1 🗌 Yes 2 ER/Outpatient 3□ DOA 27. Manner of De 1 Natural 2 Accident 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No efter death. Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours eft To the Funerel Di completaly filled in Hospital 1⊠ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2□ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 1 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 0 08, 2004 July Tuas 102 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 5505 HOPKINS BAYVIEW CIRCLE, BALTIMORE, MD. 21224 Finucane, MD I homas 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

JUL 0 9 2004

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Mitchell 10:41 AM Rosalie July 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town or Location of Death Examiner RAVENWOOD LUTERAN VILLAGE HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 73 Yrs Director 218-30-8623 Sept. 6, 1930 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r than "natural", or itams 23s or 28s-f show the Medical Examinar must be notified at 1 X Yes 2 ☐ No Hagerstown Washington Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 1032 Beechwood Dr. 21740 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1952-54 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore. Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 Widowed 4 N Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Hospital Nursing Nursing .. Pages 1 and 2 should be filed v tment of Heath and Mental Hygie tant: if itam 27 is marked othar t jury or other traumatic evant, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ellen Bertha Wolfinger Milford Boward Daniel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catherine L. Banzhoff / Sister 1011 Williamsport Pike, Falling Waters, WV 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition July compten, crematory or other place) Uniformed Services University 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 2004 Bethesda, MD 4 ☑ Donation 5 ☐ Other (Specify) Rapp Funeral Facility Cremation Services 933 Gist Ave., Silver Spring, MD 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEU MONIA **Physician** 9 day disease or condition resulting in death) aspiration /Medical Due to (or as a consequence of): Examiner myosth omer 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Examiner the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy signed by the atte Month Day 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 3 No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, ٩ o 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: After or Attanding 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D28365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagestown 368 MANZAR JSHAFI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Rosalie Anne

MITCHELL.

				For	State of Marylan	•	ent of Health and N	lental Hyg	iene	
				1 - State Registrar		Certific	ate of Death		eg. No 1	21460
		Physici		1. Decedent's Name (First, Middle, Las	F. Ma	nley		2. Date of Dea	Day Year	3. Time of Death
	1.5	/Medid Examir		4a. Facility Name (If not institution, give	street and number)	4b. (	City, Town, or Location of Death	Dury	4c. County of Death	1, 2,10
				Joseph R	chey Hos	PICE	Baltimor nder 1 Year   If Under 24 Hrs.	e La Data et Bieth	I N/	4
		Funeral Director		5. Social Security Number 6. Sec. 5. 444-17-7224	ex M 2□ F 95	Yrs. Mon		8. Date of Birth (Month, Day)	0,1909 Nor	place (State or Foreign intry)
		and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Location			7	10d. Inside City Limits
		Maryl	to	Maculand N/	AF	11.	nore			1 XYes 2 □ No
		or 28s	Director	10e. Street and Number	Λ.		. Zip Code	1	0g. Citizen of What Cou	untry?
		ns 23a	Funerai	2215 E   511	nore Hve 12. Was Decedent Ever in U.	S. 13. Was D	ecedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	ican Indian.
	9	after d or itan miner		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ANo If Yes, Give	If Yes,	specify Cuban, Mexican, Puerto es 2 No Specify:	Rican, etc.)	Black, White	
	21215-0036	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:		Usual Occupation		Specify: 16b. Kind of Business/li	ack
	215	hin 72 9. an "na Modic	Completed	(Specify only highest gra	de completed)  College (1-4or 5+)	(Give kind o	of work done during most of work of use retired)	ang A	A Dustriessyll	loosily
	121	iled wii Hygien har th		17. Father's Name (First, Middle, Last)	0	Selt	- Employe	d First Middle	Groce	ry
	Maryland	permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23a or 28a-1 show amy oritant or other traumatic avant, the Moulcal Examinar must be notified at 2008.	To Be	Charlie	Manley		Mar	(First, Middle, )	Ha	/
	lary	2 shou and M is mar is mar	ļ-	19a. Informant's Name/Relationship (7	Type, Print) [wife]	19b. Mailing Add	Iress (Street and Number or Rul	ral Route Number	, City or Town, State, Zi	p Code)
<		1 and Health am 27 ithar tr		20a. Method of Disposition	erts Manley	2215	ESINORE	Aue, E	20c. Location - City or T	d. 21216
A	mor	Pages nent of I int: If its iry or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ • 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, crematory	or other place) 7/9/	2004	Glen Rur	nio Md
0	Baltimore,	permii. Pa Departmer Important: any injury		21. Signature of Funeral Service Licen	SOP (1)	32. Nam	e and Address of Facility	Funera	Home	The production of the same of
3		₫ Ω Ξ <b>ë</b> Q		23a. Part I Enter the disease, or comp	plications that caused the deatl	Do not enter the	mode of dying, such as cardiac	ve Ba	Ito: Md. 2	Approximate
		Physician		shook, or heart failure. List only immediate Cause (Final disease or condition	one cause on each line.	7. L. 0	17			Interval Between Onset and Death
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डे			e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence of):				
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	30X	leath certifica attending ph I for use as t	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna		ic pregnancy		23d. Date of deliv	,
12	O. E	0 0 2	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	eath 5 Other	r (specify)		Month	Day Year
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07	of V	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐			ome 5 Reside		N) HOSPICE
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		To the Hospital or Attanding Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ledical	(Check only 2   Medical Examone)	niner: On the basis of examinal and manner stated.	tion and/or investige	rred at the time, date and place, ation, in my opinion, death occur	red at the time, da	ate and place, and due t	to the cause(s)
_		To the To the Comp	Σ	29b. Signature and title of certifier			29c. License number	25	9d. Date signed (Month,	Day, Year)
		1,		30. Name and address of person who	completed cause of death (Item	1 23a) (Type Print)	224170		July 6, 2	2004
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ine	er	4a. Facility Name (If not institution Stella Maris He				4b. City, Town, o		or Death				ore Co.
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		Sharon L. Bo		ghter		09 Golden						
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State Registrar

JUL 0 9 2004

			1_ For State	State of Marylar			nt of Heal		lental Hy		2001	21160
6	71 olas	1	Registrar  1. Decedent's Name (First, Middle, Last)		Cert	unca	le oi Dec	alli	2. Date of De	Reg. No	2004	3. Time of Death
	Physici		- 1	DACPHER	SON				-Month July	O co	2004	11:07 AM
)	/Medic Examir		4a. Facility Name (If not institution, give s		-	4b. City	, Town, or Loca		- V		County of Death	1
			Howard count	y General	Hospital			imb	A		HOWA	P1)
,	Funeral Director		5. Social Security Number 6. Sex 218-26-5841	7. Age (In yrs. 75	last birthday) _ Yrs.	If Under		Jnder 24 Hrs. Durs Min.	8. Date of Bi (Month, Da NOV •	av. Year	9. Birth Con 928 MD	nplace (State or Foreign untry)
	pud .		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Loc	ation						10d. Inside City Limits
	death with the Maryland ms 23e or 28a-f show rnust be notified at	ō	MD Howard		Columb							1 □Yes 🏋 No
	28a-	Funeral Director	10e. Street and Number			_	p Code			10g. Ci	tizen of What Cou	untry?
	h with	ai D	6336 Cedar Lane			21	044			Unit	ed Stat	es
	ems ?	ner	11. Marital Status	Was Decedent Ever in L Armed Forces?		as Dec	edent of Hispan	ic Origin? (Sp	ecify Yes or No Rican, etc.)	D-	14. Race - Amer Black, White	
5-0036	172 hours after death with the Marylan "natural", or Items 23e or 28a-1 show colosi Exemples mais be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:	_			ecify:			Specify: Nic	
2-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give k	and of w	ual Occupation	most of work	ing	16b. K	ind of Business/I	ndustry
2	within 72 ene. then "na'	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT	use retired)	,				
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2	should by nd Menta markad umatic ev	은	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing	Addres					or Town, State, Zi	ip Code)
	and 2 saith a n 27 is		Andrew J. MacPhers	on	1628 I	Incl	ish Pla	co Cr	ofton.	MD	21114	
altimore,	of Ho		20a. Method of Disposition  X□ Burial 2 □ Cremation 3 □ Re	amoval from State	Place of Dispos cemetery, crem	ition (Na atory or	ime of other place)		Date		ocation - City or T	own, State
Ě	Pages ment of lant: If it jury or o		' 4 □ Donation 5 □ Other (Specify)	Mea	adowride						idge, M	
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	s - Withh								nily FH Inc. MD 21043
	- v		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dear	th. Do not ente	r the mo	de of dying, suc	ch as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		my	5 C6	udul	my	nily	n		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of).	H.	one or a constant	U				
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o,	e be execut rsician and e burial-trad	Exa	resulting in death) Last	Due to (or as a cons	ence of):							
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9 ×	eath certific attending p	Mec	IF FEMALE:	Bc. If yes, outcome of pregn.	2004					I		
ВОХ	attend for us	by Physician/Me	in the past 12 months?	1☐Live birth 2☐Feta 4☐Pregnant at time of c	al death 3 🗆	Ectopic p	oregnancy				23d. Date of delive Month	ery Day Year
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ري ت	s that ined b e deta	y Pi	Part II. Other significant conditions con	tributing to death but not res	sulting in the und	derlying	cause given ig f	Part I.	23e. Did t	obacco i	use contribute to	the cause of death?
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Records,	e law re has be je 2 sho	Completed							24a. Was	OSV	24b. Were auto	opsy findings available ompletion of cause of
		Con							perfo	rmed?	death?	2□ No
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ō	Phys	1.	1 ☐ Yes 2 No	28a. Date of Injury	ER/Outpatient 28b. Time of		UA 41		me 5 Resident		6 Other (Speci	fy)
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Division of	of or Attendiater death.  Diractor: A in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, streety)	et, facto	ry, office		28f. Location (3 City or Tox		d Number or Rur )	al Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funarel Director: After this certific completely filled in by the funeral director.		29a. Certifier  (Check only 21 Medical Examin	ician: To the best of my kno er: On the basis of examina	owledge, death	occurre	at the time, da	ite and place.	and due to the	cause(s)	and manner as s	stated.
	tha H nin 24 tha F pplete	<b>ledical</b>	one)	and manner stated.	LION BROOT HIVE							
	with To COL	Σ	29b. Signature and title of certifier	M		29	c. License num				e signed (Month,	
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	Sta Registi		31. Date filed (Month, Day, Year)	32 Registrar's Signa	dure	la	1.					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year July 6, **Physician** 2004 12:15 and MARKOW /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, APR 18, 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax Birthplace (State or Foreign
Country) **Funeral** Days Hours Min. 1□M 2□F ČÁNADA 92 213-10-1738 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Exempler must be notified at 1 ☐ Yes 2 🛛 No Director BALTIMORE MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 6505 WICKFIELD RD. 21209 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 ☑ No WHITE Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **PROPRIETOR** GROCERY s 1 and 2 should be filed w f Health and Mental Hygier item 27 Is marked other tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARKOW BELLA GOOK SOLOMON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 a Department of Health at Important: If item 27 Is eny injury or other trau MRS. DENA POLSKY (DAU.) 6505 WICKFIELD RD. BALTO., MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 7/7/1904 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MOSES MONTEFIORE WOODMOOR HEBREW BALTIMORE, MD ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun (rai) Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 36 hrs /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of): Examiner requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medicai as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9□ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? The law 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 22 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deat Date of Injury Certification: Director: After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DUYPOY cy 30. Name and address of person who comple d cause of death (Item 23a) (Type, Print) 6701N Charles St Baltonne NID 21204 LMD Kann MDoda 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OSBORNS Ains /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) , 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 ☐ M 25 F Director SP 22 46 216 145X Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant If item 27 is marked other then "neturel", or Items 23a or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director DARVAIO HARFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #303 21019 · A DURT 12021 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ☐ Yes Z No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 124RS BOOKES PIR BOOKKELP 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ ELARENCE MYSSOIT 0,3/2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31017 . OSBORNI EOE# 71 00007211 180E1 BULAMP 1 PRYLAN 10H0 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō = 6 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 4 □ Donation 5 □ Other (Specify): 3007 22. Name and Address of Facility 21. In turn of Funeral Service License - BELFIR, PA. CHAPLY EVANS FURGAL CHAPLL-MARYLAGO 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Chronic Immediate Cause (Final disease or condition resulting in death) Obetructive Pnysician umonuv Y1453 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Physician/Medical Examiner burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an director, page 2 autopsy performed 1 ☐ Yes 2 No Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient Other: 1 ☐ Yes 2 No Certification; To 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Fo the Hospitel or Attending Natural
Accident 5 Pending investigation 1 🗌 Yes 2 🗆 No after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho To the Fune completely fi (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of

31. Date filed (Month, Day, Year)

JUL

4aswi

0 9 2004

SCOFF

Air Maryland

pleted cause of death (Item 23a) (Type, Print)

North Awn

32. Registrar's Signature

04-04417 Vernon Owens RJD

	1	For State Registrar	State of		artment of Health and artificate of Death	•	gierie Rag. N6) () () () () ()
ysician		. Decedent's Name (First, Midde VERNON OWEN				2. Date of De Month July	ath Day Year
Medical caminer	4	a. Facility Name (If not institution University Ho		aber)	4b. City, Town, or Location of De Baltimore		4c. County of Death
neral ector		217-08-1595	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. last birthday 19 Yrs.		lin. 8. Date of Bir (Month, Da JUN 4,	th py, Year) 9. Birthplace (State or Foreig Country) MARYLAND
fiedat	1	Usual Residence of Decedent  Oa. State  IARYLAND  NA	у	10c. City, Town or L BALTIMOR			10d. Inside City Limi 1 X Yes 2 ☐ N
al birector	1	0e. Street and Number 526 N. MOUNT S	TREET		10f. Zip Code 21217		10g. Citizen of What Country?
sacinarios by Funer		1. Marital Status  1 XNever Married 2 Ma 3 Widowed 4 Divorce	Armed For	ces? 2 🌠 No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt  1 ☐ Yes 2 ☑ No Specify:	(Specify Yes or No Jerto Rican, etc.)	14. Race - American Indian, Black, White, etc. AFRICAN AMERICAN
the Medic			est grade completed)  College (1-	(Give	edent's Usual Occupation a kind of work done during most of DO NOT use retired)	working	16b. Kind of Business/Industry
van 3e		7. Father's Name (First, Middle VERNON OWENS S	R.	u .	ESTELL	Name (First, Middle E CORPREW	Maiden Surname)
har treu	L	19a. Informant's Name/Relation  ESTELLE CORPRE  20a. Method of Disposition  1	W MOTHER  3 □Removal from S	20b. Place of Disp	osition (Name of amatory or other place)	T BALTIMO	PRE, MARYLAND 21217  20c. Location - City or Town, State  LANSDOWNE, MARYLAND
any injury or ott	ľ	21. Signature of Funeral Service			2. Name and Address of Facility	WYLIE FUN	
cian dical niner		234-Paff 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	ach line.	eter the mode of dying, such as card		rrest, Approximate Interval Between Onset and Death
ial-transit  Examiner		Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	or as a consequence of):			
letached for use as the burner Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live bi	ant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
b b	1	Part II. Other significant condit	tions contributing to de	ath but not resulting in the	underlying cause given in Part 1.	23e. Did t	obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Dunknow
n p	-						
director.	1	25. Was case referred to medic examiner? 1  Yes 2 No	Hospital:	npatient 2 ER/Outpatie	nt 3 DOA Cther: 4 Nursin	Death (Check only of g Home 5 ☐ Resi	one) dence 6 □Other (Specify)
in by the funer ertification:		3 ☐ Suicide 6 ☐ Could	tigation 75 d not be mined 28e. Place buildin	of Injury h, Day Year)  28b. Time of Injury of Injury - At home, farm, song, etc. (Specify)	PM 1 Yes 2 No	Subj	ect 5 vot  Street and Number or Rural Route Number, vn, State) 1839 w. Fayeth St.
		29a. Certifier 1 Certify (Check only 2 Medics	ing Physician: To the	best of my knowledge, dea	th occurred at the time, date and pl nvestigation, in my opinion, death o	ace, and due to the ccurred at the time,	
edical C		Uney					
completely fille		29b. Signature and title of certif	1	an md	O.C.M.E.		29d. Date signed (Month, Day, Year) July 06, 2004

			For State	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 0 0 1 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0 0 0 1 0 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0 0 0 1 0 0 0 1 0 0 0 1 0 0 0 1 0 0 0 1 0 0 0 1 0 0 0 1 0 0 0 0 0 0 0 1 0						
			Registrar  1. Decedent's Name (First, Middle, L.	and the second s			2. Date of Death		3. Time of Death	
	Physici /Medio		MILDRE	> ELIZABET		TER SON	JULY	7,2004	1 1 03 PM	
	Examin	er	4a. Facility Name (If not institution, gi	ARIS HOSPICE		ty, Town, or Location of E		8 ALTI	MORE	
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. la	ast birthday) If Un	der 1 Year   If Under 24		9. Birt	hplace (State or Foreign	
	Director		Usual Residence of Decedent	1□M 2▼F	Yrs.		OCT 19	1916 M	HRYLAND	
	laryland ehow		10a. State 10b. County		, Town or Location	_			10d. Inside City Limits	
	Ba-f	Director	, bushing	IMORE CO	CKEYSV			633	1 Tyes 2 No	
	with the	i Dir	10e. Street and Number 319 WARREN	ROAD	101.	Zip Code		og. Citizen of What Co	ountry?	
	ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was De	cedent of Hispanic Origin pecify Cuban, Mexican, F	? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, Whit		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. It may be marked other then "naturei", or items 23a or 28a-f show other treumstic event, It is Medical Examinating the notified at	by Fu	1 Never Married 2 Married  3 November Married 2 Married	1 ☐ Yes 2 No If Yes, Give Year or Dates:		2 No Specify:		Specify: \	VHITE	
21215-0036	72 hou nature		15. Decedent's I (Specify only highest g	Education	16a. Decedent's U	sual Occupation work done during most or	f working 1	6b. Kind of Business	Industry	
121	within 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	/ life. DO NO	use retired)	1101001	Me CORANO	V SOCE CO	
	filed v Hygie other t	Be Co	17. Father's Name (First, Middle, Las	t)	JAKE DH	MPLE 1 ECH N 18. Mother's	Name (First, Middle, M	laiden Sumame)	K SPICE CO	
/lan	Mental Mental arked	To B	HENRY AL	BRIGHT		MA	RY GUY	MOTI		
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if itam 27 is marked other then any injury or other treumatic event, Itam Manginge.		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Addr	ess (Street and Number of	or Rural Route Number,	City or Town, State,	Zip Code)	
	t and Health		20a. Method of Disposition	20b. Pl	ace of Disposition (	ACH/MAN C	Date 2	oc. Location - City or	Town, State	
Baltimore,	Page nent o ant: if ury or		1 Surial 2 □ Cremation 3 1 □ Cremation 3 □ Other (Spec	Themonal nom State	LAD GOOW	E UNITED TO	JULY 10:04	PHOEN	IX, MD	
3alt	permit. Pa Departmen importent: any injury		21. Signature of Funeral Service Lice	ensee	22. Name	and Address of Facility	PEACEFUL ALT			
Ī	40.2 4 4		23a. Part 1. Enter the disease, or co	mplications that caused the death			335 YORK RD		Approximate	
	Pnysician	90 D	shock, or heart-failure. List onl Immediate Cause (Final disease or condition	y one cause on each line.  METASTATIO					Interval Between Onset and Death	
7	/Medical Examiner		resulting in death)	Due to (or as a consequ						
	Cxammer	Ē	Sequentially list conditions,	b. NERVE SHEA						
	buted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.						
,00	icate be executed physician and s the burial-transit	I Exa	resulting in death) Last	Due to (or as a consequ	ence of):					
68760,	icate b physic s the b	dicai		d						
ox (	n certific anding p	In/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar		pregnancy		23d. Date of de	*	
M.	e death	Physician/Me	in the past 12 months? 1 □ Yes 2X No 9 □ Unknown	4☐Pregnant at time of de 9☐ Unknown				Month	Day Year	
P.O.	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as		Part II. Other significant conditions	contributing to death but not resu	lting in the underlyir	g cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?	
rds	quires an sign uld be	ed by					1 □ Ye	s 2□No 3□Pr	obably 4x Unknown	
eco	2 2 0	Completed					24a. Was an autopsy	prior to	topsy findings available completion of cause of	
a B	sician: The law certificate has b irector, page 2 s			T			perform 1 ☐ Yes 2	X No 1 ☐ Yes	2 No	
of Vital Records,	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital: 1 Inpatient 2 E	ER/Outpatient 3	Othor	Death (Check only one ng Home 5 Resider		city) HOSPICE	
nof	ding Phys n. After this funeral di	on: T	27. Manner ol Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe hov		" HOUTTOE	
Division	Attending or death.  octor: Afte by the fune	cati	2 Accident investigate 3 Suicide 6 Could not	be an Blood of Injury . At hor	M larm street fac	1 Yes 2 No	28f Location /Stro	eet and Number or Ri	ural Route Number	
Div	e after i Direct d in by	Certification:	4 Homicide determine	building, etc. (Specify	)	tory, office	City or Town,		arar riodio ridirioor,	
	To the Hospitel or Attending Physician: The i within 24 hours after death.  To the Funerel Director: Atter this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying I	Physician: To the best of my know aminer: On the basis of examinati	vledge, death occur ion and/or investiga	ed at the time, date and plion, in my opinion, death	place, and due to the car	use(s) and manner as	s stated.	
	thin 24	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License number		d. Date signed (Mont		
	F 3 F 8			/5		D477	2	7/7/	64	
	10		30. Name and address of person wh	o completed cause of death (Item	23a) (Type, Print)	J 1 6		1		
	\		DR. TARIO MAHN 31. Date filed (Month, Day, Year)	IOOD 2300 DULAN 32. Registrar's Signat	ure /	RD. TIMON	IUM, MD 210	93	<u> </u>	
	St: Regist	ate rar	JUL 0 9 200	32 Registrar's Signat	to spo	als				
D	HMH 17 Rev 1/2	2001			161					

			1 - For State of Maryland	d / Department of He		2001 21167
	Physic		1. Decedent's Name (First, Middle, Last)  Estelle Martha Pack		2. Date of De Month	Day Year
	/Medi Exami		4a. Facility Name (If not institution, give street and number)  FRANKLIN SQUARE HOSPITE	4b. City, Town, or L	ocation of Death	4c. County of Death BO 1 1 MO P
	Funeral Director		5. Social Security Number 6. Sex 1 M 253F 95  Usual Residence of Decedent	ast birthday) If Under 1 Year Months Days	Hours Min. 8. Date of Bil (Month, Di March	th (2) Pennsylvania  9. Birthplace (State or Foreign Country) Pennsylvania
	ith the Maryland or 28e-f show	ctor		, Town or Location		10d. Inside City Limits 1 ☐ Yes 2011No
	h with th	al Director	10e. Street and Number  10 Clipper Road	10f. Zip Code 21 221		10g. Citizen of What Country? U.S.A.
980	2.2 should be filed within 72 hours after death with the Maryland 1.2 should be filed within 72 hours after death with the Maryland hand Menial Hygiene. 7 Is marked other then "naturel", or items 23e or 28e-f show treumatic event, Ita Madical Examinar must be reutified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban,	panic Origin? (Specify Yes or No. Mexican, Puerto Rican, etc.)  Specify:	
ESTELLE	within 72 h piene. r then "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12	16a. Decedent's Usual Occupation (Give kind of work done during in the DO NOT use retired)  Homemaker	ion ring most of working	16b. Kind of Business/Industry  Own Home
25+ell	2 should be filed with and Mental Hygiene. Is marked other the eumatic event, the	Be	17. Father's Name (First, Middle, Last)  Joseph Zelk	1	8. Mother's Name (First, Middle, Fnu Ertman	Maiden Sumame)
X 0	Healt Healt ther		19a. Informant's Name/Relationship (Type, Print)  Thomas Pack (Son)  20a. Method of Disposition   20b. Pla	11215 Silentwo	od Lane, Restor	er, City or Town, State, Zip Code)  n, Virginia 20191–4134
Pac Raltimor	permit. Pages Department of I Importent: If its any injury or or			ace of Disposition (Name of metery, crematory or other place)  View Crematory  22. Name and Address	July 9,2004	20c, Location - City or Town, State  Baltimore, Maryland
	Physician /Medical Examiner	L	23a. Paya. Enter the disease, or complications that caused the death. st.ck, or heart failure. List only one cause on each line.  Imm diate Cause (Final dise to ro condition resulting in death)  Due to (or as a consequence of the conditions, but the conditions, but the conditions, but the conditions, but the conditions, but the conditions, but the conditions, but the conditions that caused the death.	Do not enter the mode of dying, in the same of the sam	such as cardiac or respiratory ar	, Essex, Maryland 21221
68760	rificate be executed by physicien and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (of as a consequence of the consequen	~		
Box	that the death certifed by the attending detached for use a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deal 9 ☐ Unknown	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
ords. P	v requires that been signed t	ed by P	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given i	in Part I. 23e. Did to	bacco use contribute to the cause of death? es 2 ☑No 3 ☐ Probably 4 ☐Unknown
tai Reco	ilcian: The law ru certificate has be rector, page 2 sh	Be Completed	25. Was case referred to medical			sy prior to completion of cause of death?  2 Z No 1 ☐ Yes 2 ☐ No
Division of Vital Records, P.O.	Hospitel or Attending Physician: The law requires that the death certificate hours after death.  4 hours after death.  Funerel Director: After this certificate has been signed by the attending poly filled in by the funeral director, page 2 should be detached for use as	2	27. Manner of Death  Natural 5 Pending (Month, Day Year)    Accident investigation   Pending (Month, Day Year)	R/Outpatient 3 DOA Other:  18b. Time of Injury at Work?  M 1 Yes	6. Place of Death (Check only or 4 Nursing Home 5 Resid 28d. Describe h 5 2 No	
DIVI	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the		4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	- Yes	City or Tow	
	To the Hos within 24 h To the Fun completely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.	n and/or investigation, in my opinio	on, death occurred at the time, d	ate and place, and due to the cause(s)
	M Wil		29b. Signature and title of certifier	29c. License nu DOO 6.		9d. Date signed (Month, Day, Year) 7/8/04
	5	,	30. Name and addr ss of pers in who completed cause of death (Item 2)  ARIF SHEIKH 000 FONK IN  31. Date filed (Month, Day, Year)  32. Registrar's Signatur	Square Driv	e Baltimore	MD 21237
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signatur	& South		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** LUIS CARLOS POLANCO 2004 JUNE 7:40 P 30 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY NATIONAL INSTITUTES OF BETHESDA HEALTH If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1⋤M 2□F 51 None Yrs 22 Cali, Colombia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28e-1 show ury or other treumatic event, the Medical Examiner must be notified at 1 ▼ Yes 2 No NY Jamaica Queens Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 20892 89-11 153rd. Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. I □Yes 2 ⊠ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: Colombian Baltimore, Maryland 21215-0036 1⊠ Yes 2□ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Mechanic 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Tsabel Hurtado ၉ Carlos Polanco 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 89-11 153rd. St #3L Jamaica, NY 11432 Teresa Rivadeneira/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H importent: If its any injury or ot once. 1 □ Burial 2 ACremation 3 □ Removal from State Alexandria, VA. Metropolitan 7-2-04 \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licenses 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4217 9th. Street N.W. Washington, D.C. 20011 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ъ Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CARDIO MYS PATH 1 ☐ Yes 2 ☐ No 3 Probably ENTERO COCCA 24b. Were autopsy findings available prior to completion of cause of death?
1 100 Yes 2 □ No 24a. Was an page 2 autopsy performed? Yes 2 No or Attending Physicien: in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No 3 DOA this 28a. Ditte of Injury 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of De th Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after deatl To the Funerei Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and 0 2004 159488 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 20892 10 CENTER DRIVE, BETHESDA, MD ALBERT E. HOLT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUL 0 9 2004

			1 - For State Registrar AMEND ITEM	State of Marylan #16b PER FH G8				giene Reg. NG. () () ()	21469
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last	P. Parke	er Jr.	ty, Town, or Location of De	2. Date of De Month	Day, Year  O O 4  4c. County of Deat	3. Time of Death
	Examin Funeral Director	er	5. Social Security Number 6. S	orth Ave	B	er 1 Year   If Under 24 Hi	s. 8. Date of Bir	th 9. Birth	A pplace (State or Foreign unity) aryland
	Maryland e-f show ilied at	ctor	10a. State 10b. County	A 10c. City	y, Town or Location  Baltin	nore			10d. Inside City Limits 1
	ath with the 23a or 28 11st Le no	Funeral Director	10e. Street and Number	th Ave.		21217		10g. Citizen of What Co	9
980	72 hours after death with the Maryland natural', or Iteme 23a or 28e-f show disal Examiliat must be notified at	þ	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Origin? coerfy Cuban, Mexican, Pure 2 No Specify:	(Specify Yes or No erto Rican, etc.)	14. Race - Ame Black, White Specify: P	
21215-0036	within ane. Ihan "	Completed	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Us (Give kind of life. DO NOT	work done during most of w	orking	16b. Kind of Business/ CLOVERLAND	MILK DAIRY
Maryland	2 should be filed and Mental Hygic and Mental Hygic Is marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last) William P.	Parker S	(,	Irer	ie A.	Maiden Surname) Hawkin	S
-	1 and 2 shoul Health and Mi Sm 27 Is mer Ther traumati		19a. Informant's Name/Relationship (194)	Parker	19b. Mailing Addre	ess (Street Ind Number or I	Aural Route Numb	er, City or Town, State, 2	21217
Baltimore	t. Pa		18 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 2). Signature of Funeral Service Ligher	Removal from State	emetery, crematory o		1/2004	Balto.	Md.
Ba	permi Depa Impo any ir		23a. Part / Enter the disease, or com shock for heart failur. List only	L. Rus	VI ZZZZ	Ph L. Rus	Ave. E	eral Hon Balto, Md	Approximate Interval Between
	Pnysician /Medical		Immediate/Cause (Final disease of condition resulting in death)	a A denoca  Due to (or as a consequ	reihoma		2		Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	bDue to (or as a consequ	uence of):				
8760,	ate be executed hysician and the burial-transit	Ical Exa	that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of):				
P.O. Box 68	death certific e attending p id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetel 4 □ Pregnant at time of do 9 □ Unknown	I death 3 Ectopic			23d. Date of deli Month	very Day Year
	98	by	Part II. Other significant conditions of	ontributing to death but not resi	ulting in the underlying	g cause given in Part I.	23e. Did t	obacco use contribute to	the cause of death?
Vital Records,	The ate h page	Completed					24a. Was autor perfo 1 - Yes	osy prior to comed? death?	topsy findings available ompletion of cause of
Vita	Phyaicien: The this certificate har director, page	Be	25. Was case referred to medical examiner?	Hospital:			eath (Check only o		
of	유 두 등	atlon; To	1 Yes 2 You  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury M	28c. Injury at Work?  1 Yes 2 No		dence 6 Other (Spec now injury occurred	ify)
Division	i Sir e	Certification;	3 Suicide 6 Could not by determined	28e. Place of Injury - At he building, etc. (Specify		ory, office	28f. Location (3 City or Tox	Street and Number or Ru vn, State)	ral Route Number,
	Hospital 24 hours a Funerel I etely filled	edical		ysician: To the best of my kno ninar: On the basis of examinat and manner stated.					
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 1 1 1 N	_	9c. License number  D 4 3 3 86		29d. Date signed (Month	• • • • • • • • • • • • • • • • • • • •
r	3		30. Name and address of person who	completed cause of death (Item	1 23a) (Type, Print)		, , , \		
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 09 2004	Herand 17	ture	w Mace, B	alhmon	( UV)	(121 <del>1)</del>

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2004 JULY 6 4:30 AM ISABEL H. PALMER /Medical 4b. City, Town, or Locetion of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner POTOMAC HCR MANOR CARE POTOMAC MONTGOMERY Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1□ M 2√2 F 95 07/16/1908 MARYLAND Director 213-16-2874 Usual Residence of Decedent 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County NEXYes 2□ No Director MD MONTGOMERY ROCKVILLE 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 216 FREDERICK AVENUE 20350 Completed by Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. Never Married 2 Married 1□Yes 2∏Xo Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC SELF-EMPLOYED 12TH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ERNEST PALMER ELLANORA GREEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MADELINE P. JACKSON 612 DOUGLASS AVE, ROCKVILLE, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State LINCÓLN PARK CÉMETERY ROCKVILLE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses HOWELL FUNERAL HOME 21207 4600 LIBERTY HGHTS AV, BALTIMORE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due (o (or as a consequence of) Examiner for use es the bunel-transit Hospital or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical e to (or as a consequence of) 23b. Did tobecco usa contribute to the ceuse of death? within 24 hours after deeth.

To the Funeral Director: After this cartificate has been signed by the ecompletely tilled in by the funeral director, pege 2 should be deteched Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2/NW 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours e To the Funeral C 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of JULY, 6, 2004 cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day)

OC

32 Registrar's Signature

VON PLATT

# Amend item#27,28d,PER ME,G833,7/22/04eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	4-43/4 ap		For	tate of Maryland	d / Depa	artment of H	ealth ar	nd Mental Hy	giene		
<u> </u>	C.P	•	1 - State Registrar		Cei	tificate of L	Death		Reg. No.	U. 21L	7.1
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year 3. Time o	f Death
	/Medic		Von Millard Pla					JULY	4, 2004		0a <sup>™</sup>
	Examin	er	4a. Facility Name (If not institution, give street 1537 CHARLESTOWN COU		)	4b. City, Town, or EDGEWOOD	Location of [	Death	4c. County HARFO		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	<u> </u>	If Under 1 Year	If Under 24		th Year)	9. Birthplace (State	or Foreign
	Director		213-82-6577	<sup>2□ F</sup> 43	Yrs.	Months Days	Hours	oct. 8	, 1960	Maryland	l
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside C	itv Limits
	Maryli f sho	ō	Maryland Harford	Ed	lgewoo	٦				1 ☐ Yes	2× No
	r 28e	Director	Maryland   Hartord   10e. Street and Number	II.C	igewoo	10f. Zip Code	-1-		10g. Citizen of	What Country?	
	th with	aiD	1537 Charlestown D	rive		210	40		Ţ	JSA	
	d within 72 hours after death with the Maryland plane. rithan "neturel", or Items 23e or 28e-f show the Madical Examinating be nailfied at	Funeral		Was Decedent Ever in U.S Armed Forces?	6. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin n, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Rac Blac	e - American Indian, ck, White, etc.	
36	rs afte	by F		1 ∭ Yes 2 <b>∑X</b> No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify	white	
21215-0036	2 hou	ted t	15. Decedent's Education	on	16a. Dece	dent's Usual Occupa	ition		16b. Kind of B	usiness/Industry	
215	within 7; iene. than "n	Completed	(Specify only highest grade co	mpleted) College (1-4or 5+)	life.	kind of work done d DO NOT use retired,	)				_
2	a filed with Il Hyglene. other thai	Con	12		Shee	t Metal M				nditioning	Co.
Maryland	s 1 and 2 should be filed f Health and Mental Hyg item 27 is marked othe other treumatic event,	Be	17. Father's Name (First, Middle, Last)  Donald Millard Pla	tt Sr				Name (First, Middle la M. Sal		ne)	
Ž	2 should be and Mental is marked ( eumatic ev	ပ္	19a. Informant's Name/Relationship (Type,		19b. Mailir	ng Address (Street a		or Rural Route Numb		State, Zîp Code)	
	nd 2 salth ar		Brenda D. Platt / W					lve, Edgew			
altimore,	es 1 and 2 of Health a fitem 27 is r other trei		20a. Method of Disposition		ace of Dispo	sition (Name of natory or other place	9)	Date	20c. Location -	City or Town, State	
<u>E</u>	Page ment ent: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo `4 ☐ Donation 5 ☐ Other (Specify)	Hi]	_	Service C	- 1	7-10-04		n, Maryland	i
Balt	permit. Pages 1 Department of H Importent: If ite any Injury or ot once.		21. Signature of Fundral Service Licensee	r)	22	Name and Address Fi MCCOMAS Fi 1317 Coke	is of Facility uneral sburv	Home, P.A Road, Abir	A. nadon. M	TD 21009	
38			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one complete the complete shock of the complete shoc	ons that caused the death	. Do not ent	er the mode of dying	g, such as ca	rdiac or respiratory a	rrest,	Approximation Interval Bet	tween
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	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):						
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	uted d ansit	Examiner	Cause (Disease or injury								
ó	an an rial-tr		resulting in death) Last	Due to (or as a consequ	ence of):						
8760,	cate be executed obysician and the burial-transit	licai	d								
9	entific ding p	/Mec	IF FEMALE:	If yes, outcome of pregnar	201						
Вох	death certificate be executed e attending physician and d for use as the burial-transit	Physician/Medical	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3[	Ectopic pregnancy Other (specify)				te of delivery onth Day	Year
o.	the che	ysid		9□ Unknown							
٦,	th de de	by P	Part II. Other significant conditions contrib	uting to death but not resu	llting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use cont	ribute to the cause of o	death?
Records,	w requires been sign should be							11	Yes 2 DN6	3 Probably 4	Unknown
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a H	Th ate pag	Con							rmed? 2□No	geatr/ 1 ☐ Yes 2 ☐ No	
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of	g Phys er this eral di	1 - 1	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	IL JUDON	4 🗀 140121	28d. Describe	dence 6 Oth how injury occur	red _	
ion	Attending Proceeding Procedures After the ector: After the by the funeral	atio		DULP 7-4-04	M;40		res 2 No	The second second	t asphy:	and the second s	4
Division	or Attendate death Director:	Certification:	3 Suierds 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	per or Rural Route Nun	nber. CONO W
	oitel or urs afte orel Dir			17 140					DRUSTO	-	U) 40
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying Physicia (Check only one)	nn: To the best of my know On the basis of examinat and manner stated	vieage, deat ion and/or in	n occurred at the tim vestigation, in my op	ie, date and pointon, death	place, and due to the occurred at the time,	cause(s) and ma date and place,	anner as stated. and due to the cause(s	s)
	To the within 2 To the Complet	Mec	29b. Signature and title of certifier	. 1		29c. License	number		-	d (Month, Day, Year)	
	1		> Megante 11	re Bhell	w	00	ME		JULY 5	, 2004	
	6		30. Name and address of person who comp	leted cause of death (Item	23a) (Type,	Print)	aet p	altimore,	Marvlan	d 21201	
			31. Date filed (Month, Day, Year)	32. Registrar's Signat		Leam Street	Jel, D	CLUMINIC)	1		
	Sta Registi			Sz. Hegistrar's Signat		de					
L,		4.	111 0 9 2004	July State of St	A. 100						

DHMH 17 Rev 1/2001

ORIGINAL

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		1. Decedent's Name (First, Middle, Las	st)		Contin	ficate of		2. Date of Deat		4	3. Fime of Deat
Physician /Medical		Cleo	G.		Rathe	er		Menth 8	Day 2004	(ear	2:30a
Examiner	•	a. Facility Name (If not institution, give Future Care N.H.		-)			4b. City, Town, o Baltim	r Location of Death Ore	4c. County of NA	Death	
Funeral Director			Class of the	ge <i>(In yrs. Ia</i> : 68		If Under 1 Year Months Days	If Under 24 Hr Hours Min		Year) )4	9. Birthpl Count	ace (State or Fore
how		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locat					10	d. Inside City Lim
Be-f s	5	Md. NA			Baltim	ore					1Å Yes 2□
iffer death with the Mar ritems 23a or 28e-f si increment be notified Funeral Director	2 2	2700 N. Charles				10f. Zip Code 21218	3	11	0g. Citizen of Wh USA	at Count	ry?
		11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates:	? No		s Decedent of Hes, specify Cub		Specify Yes or No- orto Rican, etc.)	14. Race- Black, Specify:	White, e	
be filed within 72 hours a tal Hygiene. d other than "netural; o svent, the Madical Exan Be Completed by		15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or	5+)			oation during most of w	orking	16b. Kind of Busi Vari		ustry
The The Co	3 -	11th grade 7. Father's Name (First, Middle, Last)			n.	ousekee		ame (First, Middle, M			
Mental Mental arked o	5	James		Burns	3		Alma		Boyk		
and M s mar umat		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailing A	Address (Street	and Number or F	Rural Route Number,		_	Code)
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rages intent of He	2	0a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Placen	ce of Disposition etery, cremate Lng Mem	on (Name of ony or other pla Park	сө)	7-12-04	Randal.		
permit. Departri Importa any inju		21. Signature of Funeral Service Licens	en l Mason			ame and Addre		Balt 1101 E.	imore, I North A		21202
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تر <u>ب</u> آ	2	1 ☐ Yes 2 ☑ No ☐ U  7. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		Bb. Time of injury	28c. Injur	4 Nursing	Home 5 Resider 28d. Describe how		(Specify)	
within 24 hours effer death.  To the Funeral Director: After the completely filled in by the funeral Medical Certification:		3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Inj building, etc	ury - At home c. (Specify)	e, farm, street,	factory, office		28f. Location (Str. City or Town,	eet and Number ( State)	or Rural I	Route Number,
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E Se	2	9b. Signature and title of certified	12.0			29c. Licens	e number	que Tri	d. Date signed (A	Month, De	ıy, Year)
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DHMH 16 Rev 6/95

	1 - For State Registrar	State of Man		artment of Hertificate of I			Reg. No. 2	004	21473
Dhusisian	Decedent's Name (First, Middle, I.)	.ast)	0 1 -	T49		2. Date of De Month	ath Day	Year	3. Time of Death
Physician /Medical			Ruby, -			July	2	2004	5:40 AM
Examiner	4a. Fecility Name (If not institution, g				r Location of Deat	h ,	4c. Coun	ty of Death	<b>511</b>
	Carroll Hospita		In yrs. last birthda		tminster If Under 24 Hrs	. 8 Date of Bir	th		
Funeral Director	218-22-9214	1 M 2 F	77 Yrs.	Months Days	Hours Min.		y, Year) , 1927	Mary	ece (State or Foreign try) yland
and w	Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or I	ocation				10	Od. Inside City Limits
permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: If item 27 is marked other than "natural", or Itams 23a or 28a-f ehow mingortent: If item 27 is marked other than "natural", or Itams 23a or 28a-f ehow my njury or other treumatic event, the Medical Exercitar must be notified at any njury or other treumatic event. To Be Completed by Funeral Director	Maryland Car	roll		Ha	mpstead				1 ☐ Yes 2 No
289	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Count	try?
38.0	4616 Upper Beck	leysville Ro	ad		21074			USA	
ir items 23s or 28s-feotrer must be notified	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13	. Was Decedent of H	lispanic Origin? (S	Specify Yes or No	)- 14. Ri	ace - America	an Indian, etc.
seculos by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced		IIVAJ	1 ☐ Yes 2 ☑ No	Specify:		Spec		white
ted	15. Decedent's	Education	16a. Dec	edent's Usual Occup	ation	rkina	16b. Kind of	Business/Ind	lustry
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ntic event, the Medical E	17. Father's Name (First, Middle, La					me (First, Middle			
To				ling Address (Street		Elsie S			Code
27 is n	19a. Informant's Name/Relationship Clara V. Ruby,	1 //	1 1 1/2 1/2	.6 Upper B					
othe	20a. Method of Disposition		20b. Place of Dis	oosition (Name of ematory or other place	ce)	Date	20c. Location	n - City or To	wn, State
17 or	1 Donation 5 ☐ Other (Spe			d Cemeter	07/0	06/2004	Hamp	stead,	MD
nporte ny nju nce.	21. Signature Funda Service Lie	censee	723	22. Name and Addre			Funera		
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or us	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death	□Ectopic pregnancy	у			Date of delive Month	ry Day Year
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cate has been signed to page 2 should be detected by Picture Completed by Picture and page 2						24a. Was	24	Were autor	psy findings available
0 CI						auto		prior to con death?	npletion of cause of
certificate rector, pag					05 Place of De	1 ☐ Yes		1 🗆 Yes	2 No
this certificate hard director, page	examiner?	Hospital: 1 Inpatient	2 ER/Outpat	ent 3 DOA Ott	ner.	Home 5 Res		ther (Specifi	()
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fune	1 Natural 5 Pending 2 Accident investiga	(Month, Day )	Year) Injun		rk? ]Yes 2 ☐ No				
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To the Funeral Director. After thi completely filled in by the funeral Medical Certification: T	one)	and manner state							
T COM	29b. Signature and title of certifier	1-11-	. ~	29c. Licens		ì	29d. Date sign	nea ( <i>Mionin</i> , i	
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	30. Name and address of person w Rolyardo Fala				200 Mars	(na) A. 12 -	us libet	and the	MD 21157
State	De Des Glad (Marth Con Vees)	32. Registrar		· - I CONTEY	200 Hemo	AINT HACK	UC WEST	WIND LCA	111/21111
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 10:35 ROGERS 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARYI BALTIMORE OF HOSPITAL LAND If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth 9. Birthptace (State or Foreign **Funeral** 1 **№** M 2 🗆 F Director Jsual Residence of Decedent filed within 72 hours after death with the Maryland 10d. tnside City Limits 10a. State 10b. County City, Town or Location ral, or Itams 23a or 28e-f show Exer, ther notes be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 36 21225 Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1. Marital Status 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No es. Give Specify: þ Blac 3 Widowed 4 Divorced ear or Dates 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) reumatic event, the Medical 16b. Kind of Business/Industry and Mantal Hygiena. than Cotlege (1-4or 5+) 's Name (First Middle Last) Be Pages 1 and 2 should ba f nent of Health and Mantal I ont: If item 27 Is marked of 19b. Mailing Address (Street and Number or Rural Route Number ant: If item 27 Is . 'y or other 20b. Place of Disposition cemetery, crematory Oa. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Department o Importent: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License OR or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each tine. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA /Medical Due to (or as a consequence of): **Examiner** (ARDIOMY UP ATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit BANDYLARDIA Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 Yes 2 No Day for 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 Yes 2 □ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an certificate has autopsy performed 2□ No 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: Other: 2 € No 1 Inpatient dire 2 1 🗌 Yes 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 1 Naturat 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No al Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) n by determined 4 \( \text{Homicide} \) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier

To the Hospitel or Attending Physicien: within 24 hours a To the Funeral C

> State Registrar

Medicai

29b. Signature and title of certifier

GEOFFREY

ed (Month, Day, Year)

0 9 2004

DHMH 17 Rev 1/2001

M.D

M.D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MCURER

29c. License number

AUHI76435M 1512

29d. Date signed (Month, Day, Year)

7-2-04

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Manyland / Department of Health and Mental Hygiene
		1- State of Maryland Department of Health and Mental Hygiene 1- State Amend Item 5 per fh G833 7/13/04 tas  Certificate of Death  Reg. No. 0 0 4 2 1 4 7 5
Physic /Med		1. Decedent's Name (First, Middle, Last)  Violet J. Renshaw  2. Date of Death Month Day Year 7.45 PM
Exam		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death,  The street and number of the street and number
Funera Directo		Franklin Square His bital (ent) Kosedale Balti Move  5. Sort Jacque Hos bital (ent) Kosedale Balti Move  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day Year)  1 M 25 90 Yrs. Months Days Hours Min. Dec. 29, 1913  9. Birthplace (State or Foreign Month) Days Year) Pennsylvania
and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits
Maryl 9-f sho	tor	Maryland Baltimore Dundalk 1 Tes 2 De No
with the	Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7037 Dunbar Road 21222 United States
death ms 23	neral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
1215-0036 within 72 hours after death with the Maryland ene. then "neturel", or items 23s or 28e-f show its Marical Examiter and the natified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:  1 ☐ Yes 2 ☑ No Specify: Specify: White
15-0	leted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use natired)  16b. Kind of Business/Industry
21215-0036 ad within 72 hours at giene. er then "neturel", or	dmo	Elementary/Secondary (0-12) 12 Years  College (1-4or 5+) Homemaker Own Home
ind be file tal Hy doth event	To Be C	17. Father's Name (First, Middle, Last)  Norman Finley  18. Mother's Name (First, Middle, Maiden Sumame)  Elsie Fromme
t, Maryla and 2 should salth and Men n 27 Is marke ter treumatic	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8114 Gray Haven Road Dundalk, Maryland 21222
Baltimore, permit. Pages 1 at Department of Hes Importent: if item any injury or othe		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  3
Baltimo	. Killing	21. Signatur of uneral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dillure. List only one cause on each line.  Approximate Interval Between Constitution Constit
Physician /Medica	ı	Immediate Cause (Emal disease or condition resulting in death)  a. Myo Cardial To Farction  Due to (or as a consequence of):
Examine		Sequentially list conditions, b. Due to (or as a consequence of):
and I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  C
60 be e	<u>a</u>	resulting in death) Last  Due to (or as a consequence of):  d
I Records, P.O. Box 68760.  The law requires that the death certificate be eastern been signed by the attending physician age 2 should be detached for use as the burial	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
s that the dended by the		9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
cords, P w requires that been signed b should be deta	ted b	Transient Ischemic Attacks 15 Yes 2 No 3 Probably 4 Unknown
Vital Records, sicten: The law requires to certificate has been signe irrector, page 2 should be.	Completed by	Chronic Obstructive Pulmonary Diskase 24a. Was an autopsy performed?  1 Yes 22 No 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 22 No
Vita nicien: certific rector,	Be	25. Was case referred to medical examiner?  Hospital: Hospital: 45 leastingt of EB/Outpatient of Dodd Other: 45 Decidence of Detail (Check only one)
vision of Vital Attending Physicien: or death. ector: After this certifical by the funeral director, to	tion: To	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day Year)  1 Natural 5 Pending  1 Natural 5 Pending
Division of a or Attending Phy after death. Director: After this in by the funeral d	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division of Vital Re To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  122 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
To the within To the	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
. ^		Much P. Bullock D219014 070604
10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Pr Nicole Bullock 9000 Franklin Square Dirive Baltimore, Md 2/237  31. Date filed (Month, Day, Year)  32. Registrar's Signature
S Regis	tate trar	JUL 0 9 2004 Seems & Source

DHMH 17 Rev 1/2001

Renshaw Violet

ORIGINAL

			1 - For State Registrar		State of	Marylar				lealth a	and M		Reg. Nø.	001		214	7.6
	Physici	ian	1. Decedent's Name (First, Mide									2. Date of De Month	Day		eer	3. Time of	Death
-	-/Medi	cal	4a. Facility Name (If not instituti		and H. H		ger	4h Cih	Town	Location o	f Death	July	55_	200 County of		1942	2M
	Examir	ner	Howard County					1 '	lumb		n Dodin			oward	_		
	Funeral		5. Social Security Number	6. Sex	x 7		last birthday)		r 1 Year	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da				place (State or	r Foreign
	Director		215 05 8822 Usual Residence of Decedent	128	M 2□F	94	Yrs.	<u></u>	Days	Hours	MIII.	Dec 10	, 19	09	Mar	yland	
	irylan thow		10a. State 10b. Count	у		10c. Ci	ity, Town or Lo	ocation							1	0d. Inside Cit 1 ☐ Yes	
	Ba-1 s	octo	MD How	ard			Elli∞t		ty Code				10- 010	zen of Wh			25,10
	with th	ā	10e. Street and Number 3037 Fawnwood	Driv	70				1042				-	ited			
	heath	eral	11. Marital Status		12. Was Deced		J.S. 13.			ispanic Orig	gin? (Sp	ecify Yes or No Rican, etc.)		4. Race -	Americ	an Indian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show may injury or other traumatic event, i're Medical Evantral rusal ce notified at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce		Armed Ford  1 Yes 2  If Yes, Give  Year or Da	2 <b>⊠</b> No		If Yes, spe 1 ☐ Yes		n, Mexican Specify:	, Puerto	Hican, etc.)		Black, Specify:	white. Whi		
9	2 hou	ted	15. Decede (Specify only high	nt's Edu	cation		16a. Dece	dent's Usu	al Occupa	ation during most	of work	ina	16b. Kir	nd of Busin	ness/ln	dustry	
218	thin 7 e. lan "r	Completed	Elementary/Secondary (0-12)	esi grad	College (1-	4or 5+)	life.	DO NOT	ise retired	)		y	_	~ -	_		
21	e filed within al Hygiene. I other than "vent, the Me	ပ္ပ		( == 1)	4		Mecha	mica	L Eng			e (First, Middle		G &			
Maryland	ould be fil Mental H arked ott	To Be	17. Father's Name (First, Middle Harry Reisinge				_			Ella	a	un	know	n			
	and 2 should and and 27 is ma		19a. Informant's Name/Relation  John Reisinger					•				rks, MD			ate, Zip	Code)	
ē,	s 1 ar		20a. Method of Disposition				Place of Dispo cemetery, crei	matonior	other place	(8)		Date	20c. Lo	cation - Ci	ty or To	wn, State	
E	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	3 ∐F <i>Specify)</i>	entomb	nënt Di	ruid Ri	.dge	Cemet	ery	7-8-	2004	Bal	timor	æ,	MD	
Baltimore,	permit. Departr Imports any inju		21. Signature of Funeral Service	e Licens	whh	M01044						ry H. W ike Ell					
	-		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final	or compl st only or						g, such as	cardiac (	or respiratory a	rrest,			Approximate Interval Betw Onset and D	veen
	Physician /Medical Examiner		disease or condition resulting in death)		Due to (c	ertensi		.CLIO	.1								
	beti nsit	Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	₹	0.	r as a consec											
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687	certificate iding physise as the				J												
O. Box	ath cer attendir for use	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2		th 2 ☐ Feta untat time of o	aldeath 3	∃Ectopic p ∃ Other (s					2	3d. Date o Month		*	'ear
α.	es that the de igned by the a be detached	by Ph	Part II. Other significant condi	tions co	ntributing to dea	ath but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did t	obacco us			e cause of de	
ırd	v requires been sign should be	ed	Cardiomyopathy									10	Yes 2□	]No 31	☐ Prob	ably 4 <b>∑</b> Ui	nknown
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Vital	ysician: Th iis certificate director, pag	Be C	25. Was case referred to medic examiner?	al								Check only o	ne)				
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ion o	ng fter ine	ation:	27. Manner of Death  1 Natural 5 Pend 2 Accident inves	ling tigation	28a. Date of (Month	f Injury I, Day Year)	28b. Time o Injury	M	28c. Injun Worl 1 🗀 '	/at ⟨? Yes 2 □ h		28d. Describe t	now injury	occurred			
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	d not be mined	28e. Płace o buildin	of Injury - At h g, etc. <i>(Speci</i>	nome, farm, sti fy)	reet, factor	y, office			28f. Location (S City or To		Number (	or Rura	l Route Numb	ier,
	Hospit     24 hour     Funers     etely fille	edicai (	29a. Certifier 1 XCertify (Check only one) 2 Medical	ing Phy Il Exemi	sicien: To the tiner: On the barand manner	sis of examina	owledge, deat ation and/or in	h occurred vestigation	at the tin	ne, date and pinion, deat	d place, h occurr	and due to the ed at the time,	cause(s) date and	and mann place, and	er as st	ated. the cause(s)	
	To th within To th	Me	29b. Signature and title of certif	ier				29	c. License	number			29d. Date	signed (A	Month,	Day, Year)	
			> perom	K	uck		MO	1	4D 02	25004			July	7 5,	200	4	
	10		30. Name and address of person					Print)				,	-	-			
	\	72	Levan Kuck, Ho	ward	County			nita	1 Co]	Lumbia	a, M	)					
	Sta Regist	ate rar	31. Date filed (Month, Day, Yea	9 20	04 32. Hg	gistrar's Sign	di di	4	POLK								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 13:20 July 2004 Margaret Cecilia Ray /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Upper Chesapeake Health Center Bel Air
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Days Hours 216-12-5492 Yrs. Director 98 May 3, 1906 Marvland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Maryland | Harford Fallston Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21047 USA 2110 Hampshire Dr. Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'netural', or 1 ☐ Yes 2 No Specify: ۵ Specify: 3 ™ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other then Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I Pauline (unk) Lurz Joseph (unk) Edelman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor R. Hoffman 2110 Hampshire Dr., Fallston, Maryland 21047 f Health i 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Depertment of H
Importent: If Ite
any Injury or ot
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery Baltimore, Maryland \* 4 Donation 5 Other (Specify) 7/9/2004 21. Signatura of Funeral Service Lie 22. Name and Address of Facility
Mc Comas Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

21000

Approximate Interval Between Onset and Death Immediate Cause (Final CEREBRAL Physician. EDEMA 36 HOURS. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACCI DENT 36 HOURS CEREBRO UASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MYO CARDIAL ACUTE INFARCTION 1 Yes 2 No 3 Probably 4 Unknown Completed CHRONIC RENAL 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Ves 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, filled in by the t **Director**: within 24 hours after To the Funerel Dire completely

Margaret

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier De n.D.

29c. License number

D 21207

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VELLA-CAMILLERI M.D.

21286 5 MIDCREST COURT BALTIMORE MID

29d. Date signed (Month, Day, Year)

6TH

2004

State Registrar

h

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** STEVENSON DORIS 04 JULY 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NA Baltimore Bon Secour Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

68 Yrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Md. 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 💢 F 68 213-32-4479 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b Counts 10a State "neturel", or items 23e or 28e-f show dical Examiner must be notified at 1X Yes 2 ☐ No Director Baltimore Md. NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21223 104 N. Payson Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Black Specifyþ 3 → Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) C & P Telephone Janitorial 6th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robinson Elsie Μ. Unkn 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other tree QDCS. 3722 E. Pratt Street 1st Floor, Baltimore, Md. Bernadette Anderson Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Greenmount Cem. 7-8-04 Baltimore, Md. \*4 □Donation 5 □Other (Specify) Baltimore, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Lie 1101 E. North Ave. March F.H. East West 23a, Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MULTI SYSTEM DRGAN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ISCHEMIC 130WE2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed ARTERIOSCLEROTIC Due to (or as a consequence of) Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) \_ P.O. the a 9□ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 Yes 2 No 3 Probably 4 Unknown CEREBRO - VASCULAR Completed HYPERTENTION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy BISEASE 1 ☐ Yes 2 KNo 2 No Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation after death. 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number ND. D 23300 July 04 130N SECULIES HOSP, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO. ST. BALTO MD 21213 PATE2 ND. 2000 W SUDHIR. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 9 2004 Registrar

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	Physici /Medie Examir	cal	4a. Facility Name (If not institution, give	npson		4b. Cit	1.1.5	ocation of Deat	2. Date of the Month	/ !	Day Year 7 2004 4c. County of Dec	11.37 AM
	Funeral Director		V. A HOSPITAL  5. Social Security Number  217 40 4541  Usual Residence of Decedent	ex 7. Age (	In yrs. last birthday) 59 Yrs.	If Unc Month		If Under 24 Hrs Hours Min.	(Month,	Day Ya:	N/A 1945 S.	rthplace (State or Foreign country) CAROLINA
	the Maryland	rector	10a. State 10b. County MD n/A  10e. Street and Number		0c. City, Town or Lo		ip Code			10g.	Citizen of What C	10d. Inside City Limits 1, Yes 2 No country?
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatily and Mental Hygiene. Importments if time 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	/ Funeral Director	1010 W. BALITIMORE  11. Marital Status  1 XNever Married 2 Married	12. Was Decedent Ev		Was Dec If Yes, sp	-	panic Origin? (S Mexican, Puer Specify:	Specify Yes or f to Rican, etc.)		14. Race - Am Black, Wh	
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ore, Mai	ges 1 and 2 st of Health and If item 27 Is n or other traum		19a. Informant's Name/Relationship (IGUS SIMPSON (UNCLE)  20a. Method of Disposition  1XI poral 2 □ Cremation 3 □	C)	1281 20b. Place of Dispo	WALE sition (Natory of	ER AVI	E. BALT	IMORE,	MARY 20c.	V or Town, State,  TLAND 21:  Location - City o	239 r Town, State
Baltimore,	permit. Pag Department Important: any injury o		4 Donation 5 □ Other (Specifications of Funeral Service/Licenses)	v) //		. Name	and Address	of Facility C	ALVIN B	. SC		ARYLAND JNERAL HOME RYLAND 21213
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** RANKLIN 6:51 2004 /Medical 4a. Facility Name If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner piTA Rose If Under 1 Year IIMORE HOS MARE 8. Date of Birth Month, Day, Years Birthplace (State or Foreign Country) 5. Social Security Number Sex 1 M 2 □ F 7. Age (In y/s. last birthday) **Funeral** Months Days Hours Min 219-26-7431 Usual Residence of Decedent Yrs. Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County raf, or items 23a or 28e-f show Examinar must be notified at 1 ☐ Yes 2 No Director IT MORE SALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21234 orren Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2 No Specify: White Specify Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life.\_DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) InderwriteR PALTIMORE لحا 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha stickel cdaar 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Green leaf ATT MORE MD 2122 Date 20c. Lication - City or Town, State MD 21234 enise 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other). Moreland Men. Hark 7-12-04 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

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leath. Do not enter the mode of dying, such as cardiac or respiratory arrest,

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Approximately approximately arrest. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, shock, or heart/failure. L or complice to is that caused the dist only one callse on each line. Immediate Cause (Final 3 WEEKS SPITOTOLY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** neumonio Sequentially list conditions Due to (or as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last tructive lune Dispose the attending physician and hed for use as the burial-transit MONICOBS Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 6010 nomo 1 🗹 Yes 2 🗆 No 3 🗆 Probably 4 🗇 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Intrava Scular 24a. Was an certificate has autopsy performed Failur Renal 1 ☐ Yes 2 ☐ No 2/2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 ☐ Yes 2 Z No 1 Inpatient 5 Residence 6 ☐Other (Specify) 2 Pis funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After t Certification: the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 🗌 Yes 2 □ No Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funeral Direc 4 \ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 use of death (Item 23a) (Type Frint) 30. Name and address of person who cor ive Baltimore MD

State Registrar

Martin

31. Date filed (Month, Day, Year)

Sheri

1000 Franklin

32. Registrar's Signature

			AMEND ITEM #26 PE	State of Maryla R PHY G833 7/0					giene Reg. No 20	n L 2	1181
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	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hr	S. 8. Date of Birt	Year)	9. Birthplace	(State or Foreign
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altimore,	Page nent c ant: If ury or		12 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State y) H				/9/2004 ]			_
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Division of Vital Records,	on the mospiler of Attendition within 24 hours effect death.  To the Funeral Director: A completely filled in by the funeral of the funeral or the funeral o	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined					28f. Location (S. City or Town		er or Rural Rou	te Number,
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8	11		30. Name and address of person who	ergon Jr. Wh		rint) Lanches	401 R1 1	Manc Ups	tel in	10 21	12
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sign		land.	/	701	<i>y</i> •		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 5, Year 2004 **Physician** 4:00 a M Henry Benjamin Simmons /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Street Hart Heritage Estate If Under 1 Year If Under 24 Hrs. Months Days Hours Min. April Day (Month Day) 9. Birthplace (State or Foreign Marry Land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 72 218-26-2835 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10b County 28a-f show the Medical Examiner must be notified at Kingsville 1 □ Yes 2 □ No Harford Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 United States 21087 238 2521 Whitt Road death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. small starts 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 25 Married ò 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) bakery route salesman permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, the anglesis and the properties of the property of the property and the property of the prope 12 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emma Kennel Henry B. Simmons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 2521 Whitt Road, Kingsville, Md. 21087 19a. Informant's Name/Relationship (Type, Print) Ruth Simmons/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 7/7/2004 Aberdeen, Md. Harford Mem. Gdns. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. aleun and . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UNSL Physician yenns lura /Medical Due to (or as a consequence of) Examiner on suih Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Coruns and burial-tran Due to (or as a consequence of): Box 68760. attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 ☐ Probably 4 QUnknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200

DHMH 17 Rev 1/2001

State Registrar

615

32. Registrar's Signature

W-MACPHAIL

Rel pamo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DIGRAD

31. Date filed (Month, Day, Year)

SARMUS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 2004 James Simpson Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Rose 1 timor HOSPIta dall Franklin Square If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) August 21, 1934 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1**X** M 2□ F Hours 69 Yrs. 215-30-7219 MD. Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exercities matter natified at 1 ☐ Yes 2 X No Director Baltimore Middle River Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21220 216 Shaqbark Road USA 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Shipyard Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Bethlehem Steel 12 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be find Mental I Lillian Simpson James Andrew Simpson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any injury or othar traum <u>00059.</u> 6847 Basketswitch, Newark, Md. 21841 Donna Lawrence daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, Date 20c. Location - City or Town, State 20a, Method of Disposition July 10, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore City, MD. \* 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 2004 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Funeral Service Licensee whow 7110 Sollers Point Road, Dundalk, Md. 21222 Approximate tnterval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Finat Arrhythmia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HxPoxemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the death certificate be executed the burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4☐Pregnant at time of death 5 Other (specify) be detached P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s rmed? 22 No 1□ Yes of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2☑No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After **Division** 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🔲 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To tha Funaral Directo completely filled in by the 4 - Homicide 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manager stated. 29c. License number 29d. Date signed ( onth, Day, Year) 29b. Signature and title of certifier

State Registrar

JUL 0 9 2004

Dr. Jontilburt 9000 Franklin Square Prive Baltimore MD 2123/ 31. Date filed (Month, Day, Year) 32. Registrar's Signature

N e and address of person who completed caus death (Item 23a) (Type, Print)

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D005 8671

State of Maryland / Department of Health and Mental Hygiene 1 - State Ragistra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2004 Year **Physician** 5:10 July 6, рм Stanley J. Stryjewski /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Bel Camp 1409 Primrose Place Harford If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) May 22, 1933 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 1⊠M 2□ F 71 Director Md. 216-30-6290 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-1 show amy injury or other treumatic event, it a Medical Examiner must be notified at once. 1 ☐ Yes 2X No Harford Bel Camp Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1409 Primrose Place 21017 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ If Yes, Give Year or Dates: 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Production Manager Poultry Co. 12 yrs.

17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Lillian Jenkins Joseph Frank Stryjewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1409 Primrose Place Bel Camp Md. 21017 wife Geraldine Stryjewski July 10, 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cem. Dundalk \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) months Metastatic Cancer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of): Examine this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 NO 1 Yes or Attending Physicien: 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 ANatural 5 Pending 1 Yes 2 No death. 2 Accident investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours after To the Funerel Dire 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 045390 July 7th, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYO MIN(MD.) COR South Atwood Road # 200, Bel Air, MD 21014 MYO MIN(M.D.) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra 0 9 2004

Cinthia 04-044	a J. La 11	va.	lle Salazar <b>Please</b>	Type or Print in	Black in	delible lnk	. Ensure A	All Copies A	Are Legil	ble.
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	Physici /Medi		1. Decedent's Name (First, Middle, La		azai			2. Date of Death Month July 5	n C U	Year 0844 P M
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	or Location of Death		4c. County	
40	F		303 Pleasant Ridges. Social Security Number VNK 6. S		. last birthday)	Owings N		8. Date of Birth	Balti	
87	Funeral Director		Usual Residence of Decedent	□ M 2 XF	25 Yrs.	Months Days	Hours Min.	(Month, Day,		9. Birthplace (State or Foreign Country) LIMA PEKU
	e Marylan a-f show	ctor	10a. State 10b. County	•	ity, Town or Lo	s Mi	LLS			10d. Inside City Limits 1 ☐ Yes 2 No
	with the	Funeral Director	10e. Street and Number	- 0:00-		10f. Zip Code		10	og. Citizen of W	/hat Country?
	leath v	erai	11. Marital Status	T KIDGE  12. Was Decedent Ever in U	J.S.   13 V	Vas Decedent of H	dispanic Origin? (S	pecify Ves or No.	PEK 14 Baco	- American Indian,
036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "neturel", or Items 23a or 28a-f show umatic event, the Medical Evanities investigation of the redifferent and the red ferent and	by	Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	l'	Yes, specify Cubi	dispanic Origin? (S an, Mexican, Puert Specify: PE	CUANA	Black	HISPANIC
5-0	72 hc	eted	15. Decedent's Ec (Specify only highest gra	lucation de completed)	16a. Deced	ent's Usual Occup	pation during most of wor d)	king 1	6b. Kind of Bus	siness/Industry
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Baltimore, Maryland 21215-0036	1 and 2 Health a sm 27 is		19a. Informant's Name/Relationship (1)  CHARMA RHODE  20a. Method of Disposition	n (FRIEND)	6018 Place of Dispos	OldFr			40, MC	1.21228
timor	permit. Pages Department of t Importent: If ite any injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Cometery, crem	atory or other place	1) AL 7/	21/04	LIMI	City or Town, State  4. PERU
Bali	permit Depar Impor any in		21. Signature of Funeral Service Licent	500	22	Name and Addre	ss of Facility VA			FUNERAL SEVS
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alle	sit s	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quantos of).					
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P.O. Box (	the death certificate by the attending physic ached for use as the bi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ■ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 🗌	Ectopic pregnancy Other (s <i>pecify)</i>			23d. Date Mont	of delivery th Day Year
	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions or	ontributing to death but not res	sulting in the un	derlying cause give	en in Part I.			bute to the cause of death?  B Probably 4 Minknown
of Vital Records,	law rec as bee 2 shou	Completed						24a. Was an autopsy	24b. W	ere autopsy findings available for to completion of cause of
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		n; To	27. Manner of Death	1 Inpatient 2 28a. Date of Injury  Formal, Day Year)	28b. Time of	28c. Injury	4 □ Norsing Ho	ome 5 Resident 28d. Describe how		(Specify) At Scene
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Olm dur. Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification;	4 Homicide determined	Residence				Dr.,Apt.2	204 Ow:	Pleasant Ridge ings Mills, Md
Ž	B Hosp 24 hou B Fune etely fi	Medical	29a. Certifier  (Check only one)  1 Certifying Phy 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death ation and/or invi	occurred at the time estigation, in my or	ne, date and place, pinion, death occur	and due to the cau red at the time, date	ise(s) and manr e and place, an	ner as stated. Indidue to the cause(s)
25	To the within To the compl	Me	29b. Signature and title of certifier			29c. License			in Date signed (	(Month, Day, Year)
			30. Name and address of person who d	ompleted cause of death (Item		rint)		ltimore,		
	Sta Registr	9	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature .	Soak				

		_	For State Registrar	e Type or Print in Bi State of Maryland	l / Depa		Health and N	Mental Hygi	ene g. N2 0 0	14 2   486
7	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Anna 4a. Facility Name (If not institution, g 10726 East Crest	Sevenack give street and number)		4b. City, Town, Laurel	or Location of Death	2. Date of Death Month July	Day	
	Funeral Director		170-26-6095 Usual Residence of Decedent	. Sex 1 □ M 2 ☐ F 7. Age (In yrs. Ia 9 4	Yrs.	Months Days		8. Date of Birth (Month, Day, NOV 8,	Year) 1909	9. Birthplace (State or Foreig Country) Pennsylvania
th the Marylar	or 28a-f show e notified at	Irector	10a. State 10b. County  MD Howard  10a. Street and Number		Town or Lo	10f. Zip Code	-	10	Og. Citizen of W	10d. Inside City Limits 1 □ Yes 2 □ No /hat Country?
<b>5-0036</b> 72 hours after death with the Maryland	Department of Health and Mental Hygjene. Importent: if item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other treumatic event, the Medical Exeminer must be notified at ance.	by Funeral Director	10726 East Crest  11. Marital Status  1 Never Married 2 Married  3XXVidowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces?		20723 Was Decedent of If Yes, specify Cult	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc.
121 Affhin	giene. er then "natura , the Medical E	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12) Grade 8	Education	(Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation a during most of work ad)	sing 1	6b. Kind of Bu	siness/Industry
arylan	and Mental Hygis is marked other eumatic event, I	To Be (	17. Father's Name (First, Middle, La Andrew Metro 19a. Informant's Name/Relationship		19b. Mailir	ng Address (Stree	18. Mother's Nam Elizabet and Number or Rui			
ore,	ent of Health a nt: If item 27 Is ry or other tre		Roslyn Strank /  20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe	XX emoval from State cer	ce of Dispo	6 East Consistion (Name of natory or other place) ity Chur	ace)	Date 2		aryland 2072. City or Town, State
Baltin permit. F	Department Importent: I any injury o		21. Signature of Funeral Service Lic	/ M0077	0 3	onarason 13 Talbo	rsFuneYal ott Avenue	Home, P.A	A. , Maryl	and 20707
//	ysician Medical aminer		Immediate Cause (Final disease or condition resulting in death)	omplications that caused the death.  Ily one cause on each fine.  a  Due to (or as a conseque	ene		emonte	or respiratory arre	elitet	Approximate Interval Batween Onset and Death
68760, ificate be executed	physician and the burial-transit	dical Examiner	Sequentially list conditions, by Lacong to mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseque						
O. Box	igned by the attending phy: be detached for use as the	Completed by Physician/Medic	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. tf yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	leath 3	Ectopic pregnand Other (specify)	cy		23d. Date Mon	o of delivery th Day Year
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E 20	is certificate has l director, page 2 s	Be Compl	25. Was case referred to medical	vu.			26. Place of Deat	24a. Was an autopsy perform 1 Yes 2	ed? de	fere autopsy findings available rior to completion of cause of eath?  ☐ Yes 2 ☐ No
Division of Vital	n. After th funeral	Certification: To E	examiner?  1 Yes 2 No  27. Manne Peath  1 Natural 5 Pending  2 Accident investigat  3 Suicide 6 Could not  4 Homicide	28a. Date of Injury (Month, Day Year)	R/Outpatien 8b. Time of Injury	28c. Inju	iry at ork? ] Yes 2 □ No	28d. Describe hov 28f. Location (Stree City or Town,	v injury occurre	
Di To the Hospital or	within 24 hours after death  To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  29 Medical Ex	Physician: To the best of my knowl aminer: On the basis of examination and manner stated.	ledge, death on and/or in	vestigation, in my	ime, date and place, opinion, death occur se number	red at the time, dat	te and place, ar	nner as stated.  Ind due to the cause(s)  (Month, Day, Year)
) P	\0		30. Name and address of person y	to completed cause of death (ttem 2	M 23a) (Type,	Do	0536	22	7/7/	04
	Sta Registr		Stefan Eltgroth, 31. Date filed (Month, Day, Year)  JUL 0 9 2004	M.D. 4994 Beav		ook Road	Columbia	, Marylaı	nd 210	44
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Margaret M. Smith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital Good Samaritan Baltimore 8. Date of Birth (Month, Day, Year) May 4, 1917 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2□F 87 Mary land Director 214-38-7513 Usual Residence of Decedent tha Maryland 10c. City, Town or Location 10a State 10b. County 10d, Inside City Limits Maryland N/A Baltimore 1 Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 USA 3408 Roselawn Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced event, It e Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry N/A<sup>college (1-4or 5+)</sup> Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Kelly Ethel Loats 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 406 Baldwin Park Drive Westminster Maryland 21157 Michael R. Smith/Son Health tem 27 i item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: if it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 7/7/04 Baltimore Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland Hilton Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) Examiner INFECT IUN URIMARY TRACT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be execute physician and the burial-tran Due to (or as a consequence of): Physician/Medical 687 use as IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 robably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has tirector, page 2 s 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA ð After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Vithin 24 hours after To the Funeral Div 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check? 29b. Signature and title of certifier 00060560 MS 111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PANKAJ KHETERYAL 31. Date filed (Month, Day, Year) State JUL 0 9 2004 Registrar

32, Registrar's Signature

5601

BIVD, Baltimore, MD

LOCH

			1 - For State Registrar	of Maryland		artment of H rtificate of L		_	giene Reg. No. 0	4 21488
П	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	Dav	3. Time of Death
,	/Medic	al	HENRY DIXON  4a. Facility Name (If not institution, give street and the street an		, JR.	4b City Town or	Location of Death	July	5, 2004 4c. County o	2:30 AM M
	Examin	er	Madonna Heritage, I				ettsville		1	arford
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th v Year)	Birthplace (State or Foreign Country)
	Director		578-48-2413	67	Yrs.	World Days	Tiodis Will.		4, 1936	Maryland
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Many In she	tor	Maryland Harford		Bel	Air				1 ☐ Yes 2 ☑ No
	th the	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wi	
	ath wi	Funeral Director	45 Crystal Court				1014		US	
	Itams Inerta	-une	Armed	ecedent Ever in U.S Forces? s 2 □ No	S. 13.	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	- 14. Hace Black	- American Indian, , White, etc.
930	ursaf al', or	þ	3 ☐ Widowed 4 ☐ Divorced Year o	s 2 □ No Give r Dates:		1□Yes 2√√2 No	Specify:		Specify:	White
2	72 ho	Completed	15. Decedent's Education (Specify only highest grade complete	d)	(Give	dent's Usual Occupa	during most of work	king	16b. Kind of Bus	iness/Industry
121	within ane. than	ldmo		(1-4or 5+)	_	00 NOT use retired, litary	)		U.S. G	overnment
<u>0</u>	filled Hygid other ant, t	Be Co	17. Father's Name (First, Middle, Last)	T			18. Mother's Nam	e (First, Middle,	Maiden Sumame	
aryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene.  marked other than "natural" or Itams 23a or 28a-f show marked other than "natural" or Itams 1. Itams in the molified at matic avant, it is Molified Examiliar in the molified at	To B	Henry Dixon Sturr, Sr.				Ida Mil	dred Ro	gers	
Man	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic av once.		19a. Informant's Name/Relationship (Type, Print) Mig Sturr/Wife			ng Address <i>(Street a</i> rystal Co				tate, Zip Code)
altimore,	ages 1 a nt of Hea t: If itam		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro	m State	emetery, crer	sition (Name of natory or other place ervice Co		Date	20c. Location - C	City or Town, State
Ħ	nit. Paratme vartme cortani injury		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	11111	22	. Name and Addres	s of Facility		· · · · · · · · · · · · · · · · · · ·	TID .
ñ	Dep Imp		Holle Melamas &	Smute	5 M	IcComas Fu 317 Cokes	ineral Ho Sbury Ros	me, P.A d. Abin	 adon. M	aryland 21009
П			23a. Part1. Soter the disease, or complications the shock, or heart failure. List only one cause of	i oach mio.			g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical			dvance		mentia				Orisot and Doalin
	Examiner		Due	to (or as a consequ	ience of):					
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequ	ience of):					
_	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	that initiated events	to (or as a consequ	ience of):		-			
8760,	e be e: sician s buria	dicai E	d		,					
9	rtificat ng phy as the	Aedi	IF FEMALE:							
Вох	leath certifica attending plant of for use as t	ian/I	23b. Was decedent pregnant 1 □ Liv	outcome of pregnar e birth 2 Fetal	death 3	Ectopic pregnancy			23d. Date Mont	of delivery
P.O.	that the de ed by the a detached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Un	egnant at time of de known	eath 5L	Other (specify)				
ري. ص	res that igned b be deta	by Pr	Part II. Other significant conditions contributing to	death but not resu	Ilting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
ğ	w require been sig should b							1 🗆 Y	es 2 No 3	B ☐ Probably 4 ☐ Unknown
Division of Vital Records,	ne law r has be ge 2 sh	Completed						24a. Was autop	sy pri	ere autopsy findings available ior to completion of cause of sath?
alF								1 Yes	2□No 1□	Yes 2□ No
Ĭ	siclar s certi	To Be	25. Was case referred to medical examiner?  1  Yes  XNo Hospital: 1	□Inpatient 2□E	ER/Outpatier	t 3D DOA Othe	26. Place of Deater: 4□ Nursing Ho		<i>ne)</i> dence 6 □Other	(Specify)
) of	Attanding Physician: ir death. actor: After this certifics by the funeral director, t		27. Manner of Death 28a. Da		28b. Time of				now injury occurred	
sior	andin eath. or: Af	catic	2 Accident investigation			M 1 🗆 1	Yes 2□No			
Ξ		Certification:	determined 280. Pla	ace of Injury - At hor ilding, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tox		r or Rural Route Number,
	Hospital Hospital Funaral Hely filled		29a. Certifier Certifying Physicien: To	the best of my know	wledge, death	occurred at the tim	ne, date and place,	and due to the	cause(s) and man	ner as stated.
	To the Hospital or Attanding Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	ledical	(Check only 2 Medical Examiner: On the	basis of examinati anner stated.	ion and/or in	vestigation, in my op	pinion, death occur	red at the time,	date and place, an	nd due to the cause(s)
	vith To T	Σ	29b. Signature and title of contilier	>		29c. License			29d. Date signed (	(Month, Day, Year)
	. \		20 Name assessed to a second t	Nuse of death (Item	2201/70		4296		My S,	1004
1 (	1 4		30. Name and address of person who completed on MAR AN C. RUT	-1 G-LIA A		_	29 Long	Corner I	20 TATA \$4	tehall, MD 2116
	Sta			. Registrar's Signat					WAR VIIII	-CIMILA IVIII & I I D
	Registi	ar	UU 0 9 2004	The St	BORN	ري				

			for Amend Item 11 p	Staterof Ma							lental Hygi	_	oie.	
	· ·		1. Decedent's Name (First, Middle, Last)	_							2. Date of Death Month		<del>U 4</del>	a Time of Death
	Physicia /Medic		FANNIE	В.			SILBE	ERT			JÜLY 4,	2004	Year	12:00 A <sup>M</sup>
?	Examin		4a. Facility Name (If not institution, give st.				•		Location of	of Death		4c. County		
			JEWISH CONVALESCEN  5. Social Security Number 6. Sex		(In yrs. last bi	inth do ul	BAL If Under	TIMO!	RE If Under	24 Hrs	9 Data of Birth	l .	TIMOR	
L	Funeral Director		217-62-0255	M 2 7 F	93	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 1	910	Cour	place (State or Foreign ntry) MD
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	vn or Lo	cation						1	10d. Inside City Limits
	Mary e-f sh	to	MD BALTIM	ORE	В	ALT:	IMORE							1 ☐ Yes 2 No
	th the	irec	10e. Street and Number				10f. Zip	Code			10	g. Citizen of W	/hat Cour	ntry?
	ath wi	rai	7920 SCOTTS LEVEL						2120			.,		U.S.A.
39	be filed within 72 hours after death with the Maryland ital Hygiene. So defer then "neturel", or Items 23e or 28e-f show event. Itte Medical Exam er must be redified at event.	by Funeral Director	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		ĺ	Was Deced f Yes, spec		spanic Ori n, Mexicar Specify:	gin? (Spa n, Puerto	ecify Yes or No- Rican, etc.)		k, White,	can Indian, etc. WHITE
0-10	72 hou		15. Decedent's Educa		16a	. Deced	lent's Usua kind of wor	I Occupa	ition	t of work	ina 1	6b. Kind of Bu	siness/In	dustry
21215-0036	within 7 ene. than "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	·)	life. L	DO NOT us	e retired,	)	or work		OUN HO	ME	
	iled w Hygier her th		17. Father's Name (First, Middle, Last)			0031	EWIFE		18 Mothe	r's Name	e (First, Middle, M	OWN HO		
Maryland	should be food to the marked of imatic ever	To Be	PHILLIP		L	EVII	1			TIE	T I I St, I Madre, I M		•	TAINABLE)
Man	nit. Pages 1 and 2 should arlment of Health and Men ortant: If item 27 is marke injury or other traumatic g.		19a. Informant's Name/Relationship (Type				-				Al Route Number,			
	1 and Health em 27 ther t		ALVIN L. SILBERT / 20a. Method of Disposition	SUN	20b. Place o				ING W		C - OWIN	0c. Location -		
nor	Pages nent of l int: If it		1 🛣 Burial 2 □ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)	moval from State	TIFER	ary, cren	natory or of	ther place		7/5/		ROSEDA		
Baltimore,	permit. Pages Department of Important: If i any injury or once.	Ì	21. Signature of Funeral Service Licenses	0. 1	/ 111 EK	22	. Name and	d Addres	s of Facilit	y SOL	LEVINSO	N & BRO	)S.,	INC.
	40 = # a		23a. Part1. Enter the disease, or complica	KUOWU	he death. Do						OAD - PI		.E, N	Approximate
1	Pnysician	(C U	shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line	is a to	100	Fa	Li	, such as	cardiac	or respiratory arres	21,		Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a		09:	1		10110					
	Examiner	<u>_</u>	Sequentially list conditions, b.	Cars	فالمحادث	T. S.	h	4	dla	ps	*			
	nsit	Examiner	Sequentially list conditions, from Sequentially list conditions, from Sequential Sequent	Livie to for as a	Consiguence	1	us/Co.	٠,		1				
	be executed sician and burial-transit	Exar	that initiated events c. resulting in death) Last	Due to (or as a	consequence	of):	w S	wy 1					=	
160		call	d.											
9	rtificat ng phy as th		IF FEMALE.											-
.O. Box	he death certificat the attending phy shed for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 moorns? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death		Ectopic pre					23d. Date Mon		ery Day Year
٥	ires that the de signed by the d be detached	by Ph	Part II. Other significant conditions cont	ibuting to death but	not resulting i	in the un	iderlying ca	ause give	n in Part I.					ne cause of death?
ord	w requir been si should		Hute the	the legion	a				_		1 Tes	2 1 1 10	3 🔲 Prob	ably 4 Unknown
I Records,	The lay ate has page 2	Completed									24a. Was an autopsy performe	ad?	lere auto rior to cor eath? □ Yes	psy findings available impletion of cause of 2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	- niteli				04-		of Death	(Check only one)			
of/	98	70	T Tes 25 NO	spital: 1 ☐ Inpatient 28a. Date of Injury	t 2 ER/O	-		_	4 - Tu		me 5 Residen			y)
uc.	Jing After fune	ertification:	27. Manner of beath  1 Natural 5 Pending 2 Accident investigation	(Month, Day		Time of Injury	M	Bc. Injury Work	at ? ′es 2 ∐ !		28d. Describe how	injury occurre	ea .	
Division	Attending r death. ector: After by the fune	ficat	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	y - At home, fa	arm, stre			00 20.	-	28f. Location (Stre		r or Rura	d Route Number,
Ω	al or A s after il Dire	Serti	4  Homicide determined	28e. Place of Injury building, etc.	(Specify)		, , ,				City or Town,	State)		
	To the Hospital or Attent within 24 hours after dealt To the Funeral Director: completely tilled in by the	edical C	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examine	cian: To the best of er: On the basis of e and manner state	examination ar	e, death	occurred a restigation,	at the tim in my op	e, date and inion, deat	d place, th occurr	and due to the cau ed at the time, date	se(s) and mar e and place, a	ner as st	tated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	01		_		License			290	1. Date signed	(Month,	Day, Year)
	1/		1 Trdo	, reyo	2 /	5,0,	-		3161	5		7/4	104	/
_	5		30. Name and address of person who com	~ Ave		(Type)	alti	~0	e	m	anylon	d	2)	208
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 0 9 2004	32. Registrar	's Signature	1	~ /	,						
17		. 4	- U U Z 2 0 U Z	1	/	nyse	way							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 1:44 Taylor **Physician** vank Juli 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 1114 E. Fort Avenue Baltimore City N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 12 /10/ Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days **X** M 2 ☐ F 76 215-24-4054 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD N/A Baltimore City Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 1410 E. Fort Avenue 21230 USA' 238 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 XYes 2 □ No Merchant If Yes, Give Year or Dates: Marines 1 □ Yes XXXX No Specify: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 Specify: white à XXWidowed 4 Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Longshoreman Shipping and Mental Hygin 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank J. Taylor, Sr. Rose Neubauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Importent: If item 27 Is eny Injury or other trau 1114 E. Fort Avenue, Baltimore MD Diane Taylor / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ©Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cemetery 07/08/04 Baltimore Maryland <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr.

22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 Fast Fort Avenue, Haltimore MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (o mos /Medical Due to (or as nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No Ö detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Cardiovascular eronc 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Kuphler's res Cidence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 Yes 2 No 은 Other (Specify) this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of within 24 hours after death.

To the Funeral Director: After completely filled in by the funera Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 6, 2004 39 WW 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Dart, 901 E. fart Arc Bachmore, MD ZIZZO Dart, 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

			1 — For State Registrar	State of Maryla		irtment of H			giene	004	21491		
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year	3. Time of Death		
7,	Physici /Medic		Vincent Mic		es, Jr			JULY	6	2004	12:15 AM		
	Examin	er	4a. Facility Name (If not institution, give s.	1/	111	4b. City, Town, or	TI MUR		4c. C	ounty of Death	1		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 24 H	s. 8. Date of Birt	h ,	9. Birth	place (State or Foreign		
*	Director		212-48-9686	M 2□F 5	7 Yrs.	Months Days	Hours Min	oct 25	1940		yland		
	pu s		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	cation					10d. Inside City Limits		
	Manyla f sho	jo	Maryland Baltimon		•	Balti	more				1 ☐ Yes 2√2 No		
	r 28a	Director	10e. Street and Number						10g. Citize	n of What Cou	intry?		
	72 hours after death with the Maryland Insturat; or items 23e or 28e-f show disel Examination multiple at	rai D	1806 Dalhousie Co	urt apt Tl			212	:34		USA			
	er dea	Funerai		2. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of Hi I Yes, specify Cuba	ispanic Origin? In, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	. 14	. Race - Ameri Black, White			
36	al', or	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		s	pecify:	white		
21215-0036	72 hou	Completed	15. Decedent's Educ (Specify only highest grade		(Give	ient's Usual Occupa	during most of w	rorkina	16b. Kind	of Business/Ir	ndustry		
2	within ene. then	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	0		Ca	s & Electric Co			
7	filed v Hygie other t		17. Father's Name (First, Middle, Last)	<u>4</u>		Courtain		ame (First, Middle,					
lan	lid be ked o	To Be	Vincent M. Toske	s, Sr.			Doro	othy Noll	au				
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at		19a. Informant's Name/Relationship (Typ		1					r Town, State, Zip Code)			
	and and magnetic magn	10	Richard P. Toskes	·	. Place of Dispo		rive, We	estminste:		21157	our State		
Jore	Pages 1 nent of H ant: If ite ary or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, cren	natory or other plac	107	07/2004		mpstead			
Baltimore,	- 七七方 .		*4 □ Donation 5 □ Other (Specify)  21. Signature → Funeral Service License	and the second		Cremation  Name and Address	110	Eline I		_			
Ba	Depa Impo any ir	1 12	stever!	UT 1 11	e	934 Sout	h Main	St, Hamps					
	5		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death										
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. FROBABLE MYOCARDIAL TWFARCTION										
	/Medical Examiner		700dilling in oddally	Due to (or as a cons	equence of):								
3	A 100	Jer	Sequentially list conditions, if any learning to the cause. Enter Undertying Cause (Disease or injury that initiated events c.										
	ocuted nd transit	Examiner											
60,	death certificate be executed e attending physician and id for use as the burial-transit		resulting in death) Last	Due to (or as a cons	equence of):								
68760,	icate be ex physician s the buria	Physician/Medical	d										
Box (	eath certific attending p I for use as I	n/Me	IF FEMALE: 23b. Was decedent pregnant			230	d. Date of deliv	ery					
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnancy Other (specify)				Month	Day Year		
P.0	that the do ed by the detached	Phy	9 ☐ Unknown  Part II. Other significant conditions con		aculting in the ur	aderbueg cause anu	on in Part I	23a Did to	phaceo use	contribute to I	the cause of death?		
ds,	Se Co	by	Part II. Other Significant Conditions con	modified to death out not i	esalang in the di	idenying cadse give	on mrant.		es 2 🗆				
COL	w require been si should	iete					-	24a. Was	an	24b. Were auto	opsy findings available		
Vital Records,	The lavate has	Completed				utopsy prior to co prformed2 death?		ompletion of cause of 2 No					
ital		BeC	25. Was case referred to medical examiner?	-3-01				eath (Check only o					
of V	Physician: this certific ral director,	ို	1 Yes 2 XNo		ER/Outpatien		4   Nursing	Home 5 ☐ Resid	5 Residence 6 Other (Specify)				
O LO	ding After fune	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injun Work M 1 🗀 Y	Yes 2 □ No	200. Describe i	low injury c	occurred			
Division of	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At building, etc. (Spe	home, farm, stre	eet, factory, office		28f. Location (S City or Tow		Number or Run	al Route Number,		
ā	tal or A	Cert	4   Hornoide	building, etc. (Spe	uny)			City of You	n, State)				
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one)  Certifying Physical Examination	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death ination and/or inv	a occurred at the time vestigation, in my of	ne, date and pla pinion, death oc	ce, and due to the c curred at the time, o	ause(s) ar date and pl	nd manner as s lace, and due t	stated. o the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1. 1.		29c. License				signed (Month,			
	1/1		Terme	- June		050	5570		SULY	16, 3	2004		
	711		30. Name and address of person wh	mpleted cause of death (It	tem 23a) (T. e.	Print) 5601	LOCH	RAVEN	Bou	LEVAR	0		
	Sta	i de	31. Date filed (Month, Day, Year)	XEK (110) 32. Registrar's Sig	nature	KITMORE	MAR	LAND	41	(54			
	Registi		MM1 00952004	Benefic	B 4	souls							

		_ 1	For State of N Registrar	Maryland / Depa <i>Cer</i>	artment of Hortificate of L		Re	g. Nd U U 4	21492		
ý.	Physicia	an	1. Decedent's Name (First, Middle, Last)  Helen Selma Thursby  2. Date of Death Month  July 9,						3. Time of Death		
	/Medic Examin		4b City Town or Location of Death						County of Death  Carroll		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Funeral Director		213-20-5105 1□M 2戻F	Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Jul 8, 1		hplace (State or Foreign untry) ryland		
	Maryland febow	ō	Usual Residence of Decedent 10a. State 10b. County  Maryland Carroll	10c. City, Town or Lo		Westminst	er		10d. Inside City Limits 1 ☐ Yes 2√∑ No		
36	3a or 28a-	I Director	10e. Street and Number 2627 Coon Club Road		10f. Zip Code	21157	10	g. Citizen of What Co USA	untry?		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "health Examine must be rivilled at Ance.	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decede Armed Force  1 Yes, Cive Year or Date	₹ No	Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:			
21215-0036	vithin 72 hounders.	Completed		15. Decedent's Education (Specify only highest grade completed)  Iary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Clight Owner Service							
1d 2	il Hygie other i	Be Co	12 17. Father's Name (First, Middle, Last)			18. Mother's Name					
Maryland	should be and Mental marked o umatic eve	TOE	James Chipchase Gibson	405 34-05	Add (Casaa)			.a Tarleto			
Mar	id 2 shith and 27 is m		19a. Informant's Name/Relationship (Type, Print) Patricia T. Watt, daughte		•			city or Town, State, 2 er, MD 211			
Baltimore,	Pages 1 an nent of Heai ant: If item 3 ury or other		20a. Method of Disposition  150 Burial 2 □ Cremation 3 □ Removal from Sta  4 □ Donation 5 □ Other (Specify)	110	osition (Name of matory or other place n Cemeter)	θ)	3/2004	Oc. Location - City or Baltimore			
Balti	permit. Depertir Importa any inju		21. Signature of Furtheral Service Licensee M	00723 22 UNC	2. Name and Addres			uneral Hom tead, MD 2			
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Approximate Interval Between Onset and Death  Wentle (Interval Between Onset and Death Onset)								
	/Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):								
68760,	tificate be executed ig physicien and as the burial-transit	dlcal									
.O. Box	that the death certified by the attending detached for use as	Physiclan/Me	in the pact 12 months2	h 2 ☐ Fetal death 3 ☐ ht at time of death 5 ☐	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year		
<b>Q</b>	es De	b	Part II. Other significant conditions contributing to deat	th but not resulting in the u	underlying cause giv	en in Part I.		acco use contribute to	o the cause of death?		
Records,	0 - 0	Completed	<u> </u>				24a. Was ar autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of 2 No		
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		o Oth	or	h (Check only one		Contraction - Var		
of	ding Phys h. After this funeral di	tlon: To	1 Yes 2 No 1 Inp  27. Manner of Death 1 Netural 5 Pending 2 Accident Investigation  1 Inp  28a. Date of (Month,	Injury  Day Year)  Day Year)  28b. Time of Injury	of 28c. Injur	4 Nursing Ho	28d. Describe ho	nce 6 ⊡Other (Spe w injury occurred	city)		
Division	al or Attending s after death. Il Director: Afte	Certification:	3 Suicide 6 Could not be 28e. Place of	f Injury - At home, farm, st g, etc. (Specify)	at home, farm, street, factory, office 28f. Location (Street as				ural Route Number,		
	To the Hospital or Attending 24 hours after de To the Funeral Directo completely filled in by the	Medical (	29a. Certifier (Check only one)   Certifying Physician: To the base and manne	is of examination and/or in	nvestigation, in my o	pinion, death occur	red at the time, da	ite and place, and du	e to the cause(s)		
	with Con	Σ	29b. Signature and talelof certifier		29c. Licens	3165	25	Od. Date signed (Mon	(		
	J		30. Name and add ss of per in who completed cause  Steven  31. Date filed (Month, Day, Year)  32. Reg	of death (Item 23a) (Type.	2111 h	favores	Pila	- auto	el al 1079		
	St Regist	ate trar	. IIII 0 9 2004	me by	located.						

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ORIGINAL

			State of Maryland / Depart 1- For AMEND Item 20b, per FH, G833, 7/9/9	ment of Health and Me ficate of Death	ental Hygier Reg. N	ne 2006 21602											
			1 Decedent's Name (First Middle Last)		2. Date of Death	3. Time of Death											
	Physici /Medic		MARGARET E VALCO	NTINE	JULY .	7 2004 1205 PM											
?	Examir		4a. Facility Name (If not institution, give street and number) 4	b. City, Town, or Location of Death		4c. County of Death											
			BON SECOURS HOSPITAL	BALTIMORE													
	Funeral		1 M 2 XF	f Under 1 Year If Under 24 Hrs. on this Days Hours Min.	8. Date of Birth (Month, Day, Yea 1-21-1915	9. Birthplace (State or Foreign Country) VA											
	Director		212-22-5129 89 Trs.		1-21-1913	VA											
	yland		10a. State 10b. County 10c. City, Town or Locat	ion		10d. Inside City Limits											
	a-fs	ctor	MD BALTIMOR	E		1. Yes 2 □ No											
	or 28	Director		10f. Zip Code	10g. (	Citizen of What Country?											
	ath w	ra	1831 W. LEXINGTON STREET	21223		USA											
	er de Items	Funeral	Armed Forces?	s Decedent of Hispanic Origin? (Spec es, specify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.											
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show Ita Mazical Examirer must be notified at	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 1 □ S ☒ Widowed 4 □ Divorced Year or Dates:	Yes 2 X No Specify:		Specify: BLACK											
21215-0036	2 hou atura		15. Decedent's Education 16a. Decedent	t's Usual Occupation	16b.	Kind of Business/Industry											
215	be filed within 72 ho ital Hygiene. id other than "natur event, Ire Medical	Completed	(Specify only highest grade completed) (Give kind life. DO lege (1-4or 5+)	d of work done during most of working NOT use retired)	7												
21	filed wil Hygien other th	Con		ESTIC		HOMES											
nd	should be filed within and Mental Hygiene. marked other than matic event, I've M	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (		en Sumame)											
7	should be land Mental I s marked o	우	GEORGE A. GRAY			var Taura State Zin Code)											
Maryland	2 8 8			Address (Street and Number or Rural N. MONROE ST. B		MARYLAND 21223											
	s 1 and 2 if Health item 27 other tra		20a Method of Disposition 20b. Place of Disposition	on (Name of Da	te 20c.	Location - City or Town, State											
Baltimore,	0 0		1  Burial 2  □ Cremation 3  □ Removal from State  1  □ Donation 5  □ Other (Specify)  MT ZION C			BALTIMORE, MARYLAND											
Ħ	permit. Pag Department Important: I any injury o	Ì			S A. MORT	ON & SONS F.H. INC.											
m	Deparenting Depare		James 9. Morton 17	01-31 LAURENS ST.	BALTIMO	ORE, MARYLAND 21217											
	nysician /Medical Examiner	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
			Immediate Cause (Final disease or condition ATHERO SCLEROTIC		SEASE Onset and Death												
			resulting in death)  Due to (or as a consequence of):	Due to (or as a consequence of):													
		Sequ	Sequentially list conditions, b.	Due to [or as a consequence of the consequence of t													
	led Isit	Examiner	Sequentially list conditions, 1 styleading to immediate cause. Enter Underlying Cause (Disease or injury														
	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):														
8760,	e be e siciar s buri	dical															
9	tificat ig phy as the	<b>0</b> 1															
Вох	leath certific attending pl	N/us	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ect	topic pregnancy		23d. Date of delivery											
	ed for	Physician/M	Physicia	sicia	sicia	sicis	sicia	sicia	sicia	sicis	sicia	sicia	sicia	1 Yes 4 Pregnant at time of death 5 Ot	ther (specify)		Month Day Year
P.O	that the de led by the detached			9 ☐ Unknown  Part II, Other significant conditions contributing to death but not resulting in the under	shine saves awar in Best I	220 Did tobacco	o use contribute to the cause of death?										
S,	ires the signe	by	EMPHYSEMA	nying cause given in Fait i.		2 □ No 3 □ Probably 4 □Unknown											
Ö	w require been sig should b	etec															
Vital Records,	The law cate has I page 2 s	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?											
a		e Co	25. Was case referred to medical	26. Place of Death (	1 Yes 2 N	lo 1 Yes 2 No											
Ξ	Physician: this certific ral director,	o B(	examiner?	Othor		6 ☐Other (Specify)											
	g Phy er this eral c	E id	27. Manner of Death 28a. Date of Injury 28b. Time of	1	d. Describe how inj												
0	Attending in death. sector: After by the fune	atlo	2 Accident investigation	M 1 Yes 2 No													
Division	r Atte	tific	27. Manner of Death   Statural														
D	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer																
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier Check only (Check only one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place, an ligation, in my opinion, death occurred	d due to the cause( I at the time, date ar	(s) and manner as stated. nd place, and due to the cause(s)											
	ithin 2 the the	Med	29b. Signature and title of certifies.	29c. License number	29d. D	Pate signed (Month, Day, Year)											
	⊢≯≓ŏ		Edward Segran 5 MD	D31993	-	1 7 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2											
•	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	nt)													
			EDWARD BOLGIANO MA	5000 M B	a Itima	re St 21223											
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sports													
	Registr	ar	JOL 0 3 4004														

			r lease i	ype of Finitin Die			-	_	
			For	State of Maryland			Mental Hygi	ene	0 1 1 0 1
			State Registrar		Certifica	te of Death	Re	g. NG UU4	21494
			1. Decedent's Name (First, Middle, Last	)	1	1 1	2. Date of Death Month	Day Year	3. Time of Death
- 4	Physicia /Medic		HUCKEY		N	right	July	06 200	4 18:28M
1	Examin		4a. Facility Name (If not institution, give	street and number)	4b. Cit	y, Town, or Location of Dear	th	4c. County of Deat	h
			The Johns	HODICINS H	OSpital	Baltimor		NA	
	Funeral		5. Social Security Number 6. Se	3.1 FD. F	Month	ler 1 Year If Under 24 Hrs s Days Hours Min		9. Birt	hplace (State or Foreign untry)
	Director		210-32-1309	<sup>3 M 2</sup>	Yrs.		8-21-4		Md.
	p ,	-	Usual Residence of Decedent  10a. State 10b. County	10c City 7	Town or Location				10d. Inside City Limits
	aryla shov	_		Tos. Ony,	Baltimor	••			X□Yes 2□No
	ith the Marylar or 28a-f show	ecto						g. Citizen of What Co	water/2
	vith ti	ä	10e. Street and Number		101. 2	Zip Code 21213	10	USA	ountry :
	be filed within 72 hours after death with the Maryland thygiene. At Hygiene. do ther than "natural", or items 23a or 28a-f show do ther than "natural", or items 23a or 28a-f show event, I're Medical Examinar must be natilised at	Completed by Funeral Director	1307 E. Lafayett		12 Was Dos		Specify Ves or No-	14. Race - Ame	rican Indian
	er de Item Der	'n	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White	e, etc.
36	rs aft	Ş	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: Bl	ack
Ş	hou	ed	15. Decedent's Edu		16a. Decedent's Us	sual Occupation	1	6b. Kind of Business/	Industry
15	In 72	piet	(Specify only highest grad	fe completed)	(Give kind of v life. DO NOT	work done during most of wo use retired)	erking		
12	I within jiene. r than "	E	Elementary/Secondary (0-12)  10th grade	College (1-4or 5+)	Seamstre	ess		Rockland	Industries
b	e filed withfn al Hygiene. I other than " went, II.a Me	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, M	aiden Surname)	
<u>a</u>	should be nd Mental marked o imatic eve	To B	Herbert	R. Harri	son	Ella	a	Per	rin
Maryland 21215-0036	EDEE		19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Mailing Addre	ess (Street and Number or R	ural Route Number,	City or Town, State, 2	Zip Code)
	1 and 2 s Health ar tem 27 ls other trau		Terri Byrd	Daughter	1307 E.	Lafayette Ave	e., Baltin	nore, Md.	21213
Baltimore,			20a. Method of Disposition	20b. Plac	e of Disposition (A	lame of rother place)	Date 2	Oc. Location - City or	Town, State
Ę	0 = - 0		1 Surial 2 Cremation 3 ☐F  4 ☐ Donation 5 ☐ Other (Specify,	nemoval from State	g Mem. Pa		2-04	Randallst	own, Md.
Ħ	permit. Pa Departmen Important: any injury once.	- 1	21. Signature of Funeral Service Licens	600	22. Name	and Address of Facility	Baltin	nore, Md.	21202
ä	Departiment once	8	1 Jeresa de	Kenna	March	F.H. East	llol E.	North Ave	•
	•		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death.	Do not enter the m	ode of dying, such as cardia	c or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final	Calaa Ca	0100				Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseque	nce of):				IJ MONINS
	Examiner			h.					
	,	Jer	Sequentially list conditions, if any, leaving to infine plate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Oue to (or as a conseque	nne offr		-		
N.	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events	С.					
ó	an ar		resulting in death) Last	Due to (or as a consequen	nce of):				
1760,	0 5 0	ical		d					
68	certificat nding phy use as th	Med	IF FEMALE:						
Вох	th ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de		pregnancy		23d. Date of del Month	ivery Day Year
	ed fo	sici	1 ☐ Yes 2 ☐ No	4 Pregnant at time of dea  9 Unknown	th 5 Cther	(specify)			<b>,</b>
P.0	that the de led by the a detached f	Physician/Med	9 🗷 Unknown			and a second in Part I	22a Did tob	acco use contribute to	the cause of death?
	g d	by	Part II. Other significant conditions co	intributing to death but not result	ng in the undenyin	g cause given in Fan I.			obably 4 ØUnknown
ord	w require been si should l	ompleted					10.10		
ec	law las b	ple					24a. Was an autopsy	prior to	topsy findings available completion of cause of
23		Con					perform 1 ☐ Yes 2		2 🗷 No
Vital Records,	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	I toonist.			ath (Check only one	)	
of \	Physia this c	၉	To res 212 No	Hospital: 1 ☐ Inpatient 2 ☑ EF				nce 6 Other (Spe	cify)
u u		on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 29 (Month, Day Year)	8b. Time of Injury	28c. Injury at Work?	28d. Describe how	v injury occurred	
Sio	or:	cati	2 Accident investigation 3 Suicide 6 Could not be		М	1 ☐ Yes 2 ☐ No	20f Location (Cta	not and Number or Ch	und Davida Mumbas
Division	after deat Director:	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, fact	tory, office	City or Town,	eet and Number or Ru State)	arai Houte Number,
	urs a urs a sral E	ပိ	455 C-164- Dh	reining. To the beat of each continued	-ddeath	-detthe time date and along	and due to the co	(a) and manner of	natad
	Hospital	Medicai	29a. Certifier 1  Certifying Phy (Check only one)	/sicien: To the best of my knowle iner: On the basis of examination	edge, death occurr n and/or investigati	ed at the time, date and plaction, in my opinion, death occ	e, and due to the ca curred at the time, da	ise(s) and manner as te and place, and due	to the cause(s)
	- (4 - 0	e		and manner stated.		29c. License number	29	d. Date signed (Mont	h, Day, Year)
	this the	≥	29b. Signature and title of certifier						
	To the Hospital or Atti within 24 hours after de To the Funeral Directo completely filled in by ti	2	29b. Signature and title of certifier	- M.N.		Danc 1800	_	UIV T	2004
	To the within To the comple	Σ	> WB NOUL	- MD	(2a) (Tues 5 : "	00057802	- J		2004
	To the comple	2	30. Name and address of person who co	completed cause of death (Item 2	3a) (Type, Print)	00057802	- 3		
<b>)</b>	To the within To the comple		30. Name and address of person who co		3a) (Type, Print) Johns Hop	kins Hospita	- 3		

State of Maryland / Department of Health and Mental Hygiene	
1 - State Registrar Certificate of Death Reg. No. ?	211.95
1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Ye	
Medical JAMES WAYNERS OF THE STATE OF THE ST	1-1-
Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of BALTIMORE	18
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9.	Birthplace (State or Foreign Country)
Director 2 2 4 - 54 - 09 / 9 / 7 / 7 / 7 / 7 / 7 / 7 / 7 / 7 /	VA
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
10a. State 10b. County 10c. City, Town or Location  10a. State 10b. County 10c. City, Town or Location  10b. City, Town or Location  10c. City, Town or Location  10d. Zip Code 10g. Citizen of What 1	1 2 Tes 2 □ No
10e. Street and Number 10f. Zip Code 10g. Citizen of Wha	Country?
= 146 S. Hilton Street Z1229 US	4
The street and Number    10e. Street and Number   10f. Zip Code   10g. Citizen of What   10	mencan Indian, /hite, etc.
Specify:    Specify:	Black
10a. State 10b. County 10c. City, Town or Location    Saltmane   10d. Zip Code   10g. Citizen of What   10d. Zip Code   10g. Citizen of What   10d. Zip Code   10g. Citizen of What   10d. Zip Code   10d. Zip	ess/Industry
Elementary/Secondary (0-12) College (1-4or 5+) Iffe. DO NOT use retired)  Truck Driver Se	/ <b>.</b>
Elementary/Secondary (0-12)  College (1-4or 5+)  Truck Driver  Se  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
Elementary/Secondary (0-12)  College (1-4or 5+)  Truck Driver  Se  O B O Truck Driver  18. Mother's Name (First, Middle, Maiden Surname)  To Sey  O Sey  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, States)	
	_
	or Town, tate
cemetery crematory or other place)	rere ND
1 Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  22. Name and Address of Facility  23. Signature of Funeral Service Licensee  24. Donation 5 Other (Specify)  25. Name and Address of Facility  26. Name and Address of Facility  27. Donation 5 Other (Specify)	e D.D
m ad tession Str Baltmore	10515 and
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)  Amedical  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)	-
Examiner	
Social felty list condition  if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	
f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
p p p p p p p p p p p p p p p p p p p	
W IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 1 □ Live birth 2 □ Fetal death 1 □ Live birth 2 □ Fetal death 1 □ Live birth 3 □ Ectopic pregnancy  23d. Date of Month	
So to be a serious of the serious of	Day Year
Yes 2 No 9 Unknown 9 Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributions.	e to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.  1	Probably 4 Junknown
1   Yes 2   No 3    24a. Was an autopsy performed?   1   Yes 2   Mo 1    24b. Were autopsy performed?   1   Yes 2   Mo 1    1   Yes 2   No 3    24c. Was an autopsy performed?   1   Yes 2   Mo 1    1   Yes 2   No 3	autopsy findings available
autopsy performed?  1 Yes 2 PNo 1	
1 Yes 2 PNo 1 S 2 S Was case referred to madical examiner?  Hospital: 1 Plansition: 3 FR Other: 4 Number Home 5 Participant 5 Pa	
2 2 5 0 1 1 Yes 2 2 No 1 2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (S	(pecify)
C C 2 5 0 1 □Natural 5 □ Pending (Month, Day Year) Injury Work?	
27. Manner of Death    Column	Rural Route Number,
Cert in the company of the company o	
2 Accident 3 Suicide 4 Homicide 2 Place of Injury - At home, farm, street, factory, office 2 Place	as stated. due to the cause(s)
29d. Date signed (M	onth, Day, Year)
Koputa K Cruz ms Do030355 July 3	2004
No Roth K Cru J m. S D0030355 July 3  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ROS (FA R. CRUZ M. S BOX SECOURS H.	DEDTAI
20 Designation of Circumstance	Spiric
State 31. Date filed (Month, Day, Tear)  Registrar  JUL 0 9 2004  Server & Aparla	

			1 = For Stete Registrar	State of Ma	-	epartment Certificate			Mental Hy	giene	The second secon	21496
	Physici	an	1. Decedent's Name (First, Middle,	Last)	30				2. Date of De Month	Day	Year	3. Time of Death
4.	/Medi	cal	KENNETH			45 0% 7	·	cation of De	JULY	-	04	9:159 M
	Examir	ner	4a. Facility Name (If not institution, of Bon Scour Hospi				altim		atn	4c. County	NA	
	Funeral				(In yrs. last birti	hday) If Under 1	Year If	Under 24 H	s. 8. Date of Bi	rth ,	9. Birthpla	ice (State or Foreign
	Director		230-64-8488	1 <b>X</b> M 2□F 5	8 Y	rs. Months	Days F	lours Mi	n. (Month, Da	2 46	Country	۷a.
	pu ,		Usual Residence of Decedent		10c. City, Town	as Lanatina					100	d Inside City I in the
	anyla ehov	2	10a. State 10b. County		•	altimore					100	d. Inside City Limits  X□ Yes 2 □ No
	28e-f	ecto	Md. NA		Dc	10f. Zip (	Code			10g. Citizen of W	hat Countr	
	with Me or	ā	2605 E. Preston	Street			1213			USA	nat ooding	<i>y</i> .
	72 hours after death with the Maryland "naturel", or Items 23e or 28e-f ehow idical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decede	nt of Hispa	nic Origin?	(Specify Yes or No erto Rican, etc.)	- 14. Race	- Americar	
9	or Ite	F	1 ☐ Never Married 2 ☐ <b>X</b> Married	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give	0	1 ☐ Yes 2		иехісап, Рис Specify:	erto Hican, etc.)	Specify:	, White, et	
5-0036	irel',	d by	3 Widowed 4 Divorced	Year or Dates:							Dia	
5	- 3	Completed	15. Decedent's (Specify only highest		16a.	Decedent's Usual (Give kind of work life. DO NOT use	Occupation of done during of the contract.	n ng most of w	orking	16b. Kind of Bus	siness/Indu	ıstry
2121	within ene. then "	dwo	Elementary/Secondary (0-12)  GED	College (1-4or 5-	+)	Labore				Vari	25	
<b>d</b> 2	Hygi other	BeC	17. Father's Name (First, Middle, La	est)	1	Busone.		. Mother's N	ame (First, Middle	, Maiden Surname		
<u>a</u>	should be filed within and Mental Hygiene. • marked other then " umatic event, Ire Mas	To B	Willie	P. 1	Ward			Eliza	beth	Will	iams	
Maryland	and N le me		19a. Informant's Name/Relationship	o (Tyρθe, Print)						er, City or Town, S		ode)
	of Heelth of Heelth litem 27 I		Barbara Ward	Sister	-			n Str		imore, M		21213
ore	ges 1 and 2 should be filed within to Health and Mental Hygiene. If Item 27 ie markad other then or other treumatic event, it a Ma		20a. Method of Disposition 1   Burial 2 □ Cremation 3	☐Removal from State	cemetery	Disposition (Name of crematory or oth	her place)	i	Date	20c. Location - (		
altimore,	Depertment Depertment mportent: I Iny Injury c		`4 □Donation 5 □Other (Spe		Mt. C	armel Ce			13-04	Dundalk		
Bal	permit. Pages Depertment of Importent; If i any Injury or one		21. Signature of Euneral Service Lie	-/7=	1	March	F. H	. Eas	1101	imore, M L E. Nort	h Ave	21202
Е			23a. Part1. Enter the disease, or co shock, or heart failure. List or		the death. Done	ot enter the mode	of dying, s	uch as cardi	ac or respiratory a	rrest,	l:	Approximate nterval Between Onset and Death
4	Priysician		Immediate Cause (Final disease or condition resulting in death)	a. ACUT	ie h	MAOCA	ROI	nL	Inta	rchom	)	
	/Medical Examiner		A second with a second		consequence o							
		ъ	Sequentially list conditions, if any, leading to immodute cause. Enter Underlying Cause (Disease or injury	Consequence o	f):							
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	END	STAV.	E RE	MAL	- 3	DISER	SES,		
0,	en an	Exa	resulting in death) Last	Due to (or as a	consequence o	f):						
8760,	certificate be executed rding physicien and ise as the burial-transit	dicai		d								
9	eath certific attending pl	Med	IF FEMALE:	02- 4								
Вох	ath or u	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t	2 ☐ Fetal death	3 □Ectopic pre				23d. Date Mont	of delivery	ay Year
P.O.	0 0	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ime or death	5 □ Other (spe	city)					
	es that the igned by th be detache	y Ph	Part II. Other significant condition	s contributing to death bu	t not resulting in	the underlying ca	use given ir	n Part I.	23e. Did 1	obacco use contril	oute to the	cause of death?
rds	requires een sign nould be	ed by							1 🗆	Yes 2□No 3	3 🗌 Probab	oly 4 □Unknown
00		piet							24a. Was	an 24b. W	ere autops	y findings available
Vital Records,	sicien: The law certificate has t irector, page 2 s	Completed							perfo	rmed?// de	eath?	
/ita	ysicien: is certific director,	Be (	25. Was case referred to medical examiner?				26	. Place of D	eath (Check only o	one)		
of \	this ald	은	1 Yes 2 No	Hospital:				4 Nursing	-	dence 6 Other		
	fter frei	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Ti	jury M	c. Injury at Work?	2 🗆 No	260. Describe	how injury occurre	a	
Division	Attending r death. sctor: After you the fune	licat	2 Accident investigat 3 Suicide 6 Could no	t be 200 Blace of Injur	rv - At home, fari			2 0,10	28f. Location (	Street and Number	r or Rural F	Route Number,
Div	after after Dire	Certification;	4 Homicide	building, etc.	(Specify)				City or To	wn, State)		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the best of caminer: On the basis of and manner stat	examination and	death occurred a /or investigation, i	t the time, o	date and place on, death occ	ce, and due to the curred at the time,	cause(s) and man date and place, ar	ner as state nd due to th	ed. ne cause(s)
	roth within Toth	Me	29b. Signature and title of certifier			29c.	License nu	mber		29d. Date signed	(Month, Da	ay, Year)
			p.m.	Shar mo		$\mathcal{D}$	001	96	58	29d. Date signed	Sha	L ~.
	0		30. Name and address of person wh	no completed cause of de	ath (Item 23a) (7	Type, Print)			-	0 1		. ~
	1		R.M. SHAH	1.D BOE	1 3E (	URH	rgso	TAL	Ba	Chima	e . +	~·>
	Sta Regista		31. Date filed (Month, Day, Year)	2004 32. Registral	rs Signature	G Sou	n Kal	,		ltimo		

Virginia A. Woolridge Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-04416 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** A M July 06 2004 4:40 19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Bon Secours Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 X F 212-58-513 Usual Residence of Decedent 58-573 Director the Maryland 10b. Count 10a. State 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No The marked other than "natural", or Itams 23s or 28a-f sh traumatic avent, if a Medical Exercitived by Funeral Director Maryland more 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 6 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State; 3rd ~ OR SOCIONAL CONTROL OF THE PROPERTY OF THE PRO itam 27 l Z20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of HIMPortant: If its any injury or ot once. 1 Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of reral Joseph Balto. 2222 W. North Ave. 23a. Paril. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cardiovas cular disease Atherosclevone /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. the ad by the attending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Aq Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown alcoholism Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ ← s 2 ☐ No 24a. Was an certificata has page 2 autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 3□ DQA Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification:

Division of Vital

To the Hospital or Attending Physician:

this After gafter death

within 24 hours a filled

Medical

in by

State Registrar

Loisha Zaveenber lasha

5 Pending investigation

6 ☐ Could not be

determined

1 Natural 2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier Theeres MD

and manner stated.

1 🗌 Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

2 🗌 No

29d. Date signed (Month, Day, Year)

O.C.M.E.

July 06, 2004

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of perso, who completed cause of eath (Item 23a) (Type, Print) MO. 111 Penn Street, Baltimore, Maryland 21201

32. Registrar's Signature

31. Date filed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760

o the Hospital or Attending Physician: hours after death. Ineral Director: After this y filled in by the funeral di within 24 hours a To the Funeral C completely filled

State Registrar

Medical

Tashaz reenber 32. Registrer's Signature

MUD

found at home

101

2 X Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number OCME

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29o. Date signed (Month, Day, Year) June 30, 2004

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

M.D

111 Penn Street, Baltimore, Maryland 21201

Baltimore, Maryland

31. Date liled (Month, Day, Year)

29b. Signature and title of certifier

Joista

JUL 0 9 2004

4 | Homicide

29a. Certifier

fred

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician аМ Wohlfarth 9:15 Alice Ju<sub>1</sub>v 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 500 North Patuxent Road Odenton Anne Arunde1 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M ŽCYE Yrs. Director 579-20-8221 85 Pennsylvania Usual Residence of Decedent with the Maryland 10c, City, Town or Location 10b. County 10a State 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic evant, Ita Madical Examina memusi oe notified at 1 TYes 2 X No Director Odenton Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 North Patuxent Road 21113 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Ital any injury or othar traumatic evant, the Medical Exerts as 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify lf Yes, Give Year or Dates: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aid Medicine 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stanley Ufsmith Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katharine A. Flaherty (Daughter) 719 Rainbow Court, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/27/2004 Arlington, VA Arlington National 21. Signature of Funeral Service License 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 0 Montes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No Records, P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 should be 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No 2 No 1 ☐ Yes Division of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 5 Inesidence 6 □ Other (Specify) 7 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this completely filled in by the funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral C 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) M.D 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Glan Burnie, MD Markon 305 105/21 dhish 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2004 Walters Mabel July 5:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Crofton Convalescent Center Crofton Anne Arundel 8. Date of Birth (Month, Day, Year)
Aug. 7, 19 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 XF Months Days Hours Min. Director 202-36-0486 97 1906 Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes XXNo Director 28a-f MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Itams 23a 562 Williamsburg Lane 21113 Funerai USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Itam 27 is marked other than "natural", or Ita 1 ☐ Yes 2 🛣 No If Yes, Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elmer A. Rosenkrans Ethel Grace Singer ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vera Keenapple (Daughter) 562 Williamsburg Lane, Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Newton Township Cem. 7/10/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Newton, PA 21. Signature of Funeral Service P.A. Pardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Athero Scherotic Heart Immediate Cause (Final Physician Hear disease or condition resulting in death) /Medical Examiner andriac S—uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4 Pregnant at time of death P.O. 9□ Unknown 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 27 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 25 No 2 this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attanding 1 Natural 2 Accident 5 Pending investigation death. 1 🗌 Yes 2 No Diractor: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one) and manner stated within 2 To the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) KAKESH ARURA M.D 14300 GALLANT BOWIE MD STEZZZ

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

0 9 2004

32. Registrar's Signature